

**EFFECTIVENESS OF SOCIAL SKILLS TRAINING UPON LEVELS OF
SOCIAL SKILLS AMONG SCHIZOPHERNIC CLIENTS**

BY

Ms. SATHYA NARAYANIS

**A DISSERTATION SUBMITTED TO THE TAMILNADU DR.M.G.R.MEDICAL
UNIVERSITY, CHENNAI, IN PARTIAL FULFILMENT OF THE
REQUIREMENTS FOR THE DEGREE OF MASTER
OF SCIENCE IN NURSING**

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DECLARATION

I hereby declare that the present dissertation titled **“Effectiveness of Social Skill Straining Among Schizophrenic Clients”** is the outcome of the original research work undertaken and carried out by me, under the guidance of **Dr. Latha Venkatesan, M.Sc (N), M.Phil., Ph.D.**, Principal and Professor in Obstetric and Gynecological Nursing, Apollo College of Nursing and **Mrs. Vijayalakshmi. K., M.Sc (N)**, HOD, Psychiatric Nursing, Apollo College of Nursing, Chennai. I also declare that the material of this has not formed in any way, the basis for the award of any degree or diploma in this university or any other universities.

II – Year M.Sc., (N) Student

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There is no such thing as self-made man.

You will reach goal only with the help of others-**George shinn**

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SYNOPSIS

A Quasi Experimental Study was conducted to Assess the Effectiveness of Social Skills Training Program upon Social Skills Among Schizophrenic Clients at Selected Mental Health Hospitals in Chennai.

Objectives of the Study

1. To assess the level of social skills in the control and experimental group of the schizophrenic clients before and after social skills training program.
2. To evaluate the effectiveness of social skills training by comparing the level of social skills in control and experimental group of schizophrenic clients before and after Social skills training program.
3. To determine the level of satisfaction regarding social skills training program among experimental group of schizophrenic clients.
4. To find out the association between level of social skills and selected demographic variables in control and experimental group of schizophrenic clients before and after Social skills training program.
5. To find out the association between level of social skills and selected clinical variables in control and experimental group of schizophrenic clients before and after Social skills training program.

The conceptual frame work of the study was based on Albert Bandura Social Learning Theory. A Quasi Experimental research design (one control and one experimental group pre test, post test) was considered appropriate. Thirty clients for experimental group were chosen from the Asha Psychiatric Rehabilitation Center for

Schizophrenic Clients using purposive sampling technique and thirty clients for control group were chosen from the Doctor Peter Fernandez Home for Schizophrenia using purposive sampling technique and the data was collected using demographic variable Proforma ,clinical variable Proforma,NIMHANS social skills questionnaire and rating scale on level of satisfaction of social skills training program by interview , observation and self administration methods. Content validity of the tools was established .Then the pilot study was conducted before the main study.

Social skills training program focuses on two aspects such as interpersonal domain like basic conversation, assertiveness, problem solving and domain of coping with illness like medication management, relaxation techniques, stress management and relapse prevention by using various methods such as power point presentations, group discussions, role play, and video show; aimed at promoting level of social skills .The program was conducted for 90 minutes in week days for six weeks. The level of satisfaction regarding the program was assessed in the experimental group. The post test was conducted in both experimental and control group to assess the effectiveness of social skills training. The data was analyzed using descriptive statistics (frequency, percentage, mean, standard deviation) and inferential statistics (t-test and chi square test).

Major Findings of the Study Were

- In this study most of the clients in this study were males (63%, 63%), Hindus (73%, 67%), with the family income between 5000-10,000/month (63.3%, 57%) in the control and experimental group respectively. Significant percentage of the

clients belongs to joint family (53%, 47%), aged above 50 years (43%.33%), (20%, 50%) unmarried in the control and experimental group respectively.

- In this study majority of the clients has the history of previous hospitalization (70%,83%).Most of the study clients sought help from other traditional sources (63.3%, 73.3%) for their treatment, have family history of mental illness (60%, 66.7%) and they are first degree relatives (36.7%, 53.3%) to the clients in control and experimental group respectively. Significant percentage of the clients got treatment immediately after the onset of illness (53.3%, 46.7%) in control and experimental group respectively.
- The mean percentage and standard deviation scores of social skills before social skills training program of the control and experimental group ($M = 28.2$, $SD = 4.6$) and ($M = 28.9$, $SD = 4.3$) were not significant ($p > 0.05$). On the other hand the scores of the control and experimental group after the SSTP ($M=27.8$, $SD = 4.5$) and ($M =40.7$, $SD = 4$) shows that scores of experimental group is high when compared to the scores of control group. The difference found was stastically significant at $P < 0.001$ level of confidence. Hence the study results shows that social skills training program enhance level of social skills of schizophrenic clients.
- The percentage distribution of level of satisfaction regarding social skills training program indicated that all of the schizophrenic clients in experimental group (100%) were highly satisfied.

- There was no significant association between demographic variables and level of social skills.
- There was no significant association between clinical variables and level of social skills.

Recommendations

- Study can be to assess the Effectiveness of different methods and models on social skills.
- Study can be conducted on larger sample to generalize the findings.
- Similar studies can be conducted in different settings like other psychiatric disorders, and also on different age group.
- Longitudinal study can be conducted to assess the long term effects of SSTP.

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CHAPTER - I

INTRODUCTION

Back Ground of the Study

“Training and managing your own mind is the most important skill you could ever own, In terms of both happiness and success.”

T.Haver Eker

Schizophrenia is a word derived from Greek which means “spilt mind”. Schizophrenia is heterogeneous disease entity which has various combinations of causes like genetic predisposition, biochemical dysfunction, physiological factors and psycho social stress. Schizophrenia disorder has major consequences for affected individuals and their families and society. Affected individuals may show wide range of disruptions in their ability to see, hear, and otherwise process information from the world around them. They also experience disruptions in their normal thought processes as well as their emotions and their behaviors. The other characteristic symptoms are delusions, hallucinations, social /occupational dysfunction, disorganized speech, and disorganized behavior. Negative symptoms are seen such as alogia / avolition.

Schizophrenia affects men and women equally. It occurs at similar rates in all ethnic groups around the world. Usually people affected with disorder starts to experience symptoms between ages 16 and 30, men tend to experience symptoms a little earlier than women. Most of the time, people do not get schizophrenia after age 45years.Schizophrenia rarely occurs in children, but awareness of childhood-onset schizophrenia is increasing now a days. The diagnosis of schizophrenia is difficult in teens. This is because the first signs can include a change of friends, a drop in grades,

sleep problems, and irritability—behaviors that are common among teens. A combination of factors can predict schizophrenia in up to 80 percent of youth who are at high risk of developing the illness. These factors include isolating one self and withdrawing from others, an increase in unusual thoughts and suspicions, and a family history of psychosis.

Schizophrenia affects about 24 million people worldwide and it's a severe form of mental illness affecting about 7 per thousand of adult population the incidence rate of schizophrenia is low (3-10,000) but the prevalence is high due to chronicity (WHO, 2011). The number of person affected in India is believed to be at least 7 million schizophrenia patients (Desh, 2011). The numbers of person affected in U.S are over 2 million people suffering with schizophrenia (Raman, 2009).

Social skills are interpersonal behaviors that are normative and or socially sanctioned behaviors. The term skills is used to emphasis the social competence is asset of learned performance abilities, rather the traits, needs or intra psychic processes .Conversely, poor social behavior often results of social skills deficits. Basic aspect of social behaviors are learned in child hood, while more complex behavioral repertoires, such as job interview skills, are acquired in the adolescence and young adult hood. Some elements of social competencies such as facial expressions of affect are not learned, but are genetically “hard wired” at the birth, nevertheless virtually all social behaviors are learned that is, they can be modified by experience or training.

Social dysfunction is hypothesized to result from three circumstances , when the individual does not know how to respond appropriately , when the individual does not use his skills in his /her repertoire when needed, or when appropriate behavior are undermine by the socially inappropriate behavior each of these three circumstances appears to be common in schizophrenia. Many individuals with schizophrenia have the disturbance of such basic aspects of life can be crippling, resulting in a life time disability, periodic hospitalization and a failure of family and social relationships .Many people afflicted with this disorder at some time in their life, schizophrenia is now recognized as major public health concern. The deficits are stable over time and relatively independent of other domains of illness E.g. Social impairment persists even during periods when other symptoms have remitted.

Numbers of investigators like Keith and Matthew have examined the efficacy of group therapy for schizophrenia and suggested that group therapy is effective or more effective than individual psychotherapy for many chronic patients. Several types of group therapy are available for schizophrenic clients ranging from highly structured behavior therapy groups to less structured social groups. Group therapy is well suited for teach coping and interpersonal skills and for providing a supportive social network for clients who tend to be isolated .Social skills training for schizophrenia must focus on problem solving, social interaction, manage life stress ,promote self control improve social, vocational functioning and side effect management rather than achieving insight(Christian,1995).

Social skills and social skills training have attracted considerable attention in the field of psychiatric rehabilitation in the past twenty years. There are numerous studies which says that social skills training program is most effective for the psychiatric clients in the rehabilitative phase. Social skills training consists of learning activities utilizing behavioral techniques that enable persons with schizophrenia and other disabling mental disorders to acquire interpersonal disease management and independent living skills for improved functioning in their communities. A large and growing body of research supports the efficacy and effectiveness of social skills training for schizophrenia (Kopelowicz et al., 2006).

The literature dealing with social skills training of schizophrenic clients indicates that topographical features and self-reports of anxiety and discomfort can be changed for the better by social skills training. Social skill training for schizophrenic clients improves the efficacy in psychosocial functioning.

Social skills are useful in nursing profession in many aspects like communication which is essential to communicate with the clients. Social skills training improves assertiveness in both professional (patients care) and personal aspects (family role).

Need of the Study

Schizophrenia is major mental disorder with complexities, but the two basic concepts of this disorder are it can be either acute or chronic schizophrenia. The predominant features in the acute schizophrenia are delusions, hallucinations, thought alienation lack of insight and interference with thinking features of this kind is called

positive symptoms. Some patients recover from the acute illness, whilst others progress to chronic syndrome its clinical features are totally deviant from the acute, social withdrawal, lack of conversation, socially embracing behavior, odd ideas and neglect of appearance. These features are called negative symptoms. The acute schizophrenic clients behave and appear entirely normal but changes occur in other aspects it is not so in chronic schizophrenia. The most striking feature in chronic schizophrenia is diminished volition that is lack of initiative.

Some of the etiological factors for Schizophrenia are genetic vulnerability, increased dopamine production and receptors sensitivity and some of the physiological influences are viral infection, anatomical abnormalities (ventricular enlargement), histological changes, and physical conditions (epilepsy). Some of the other etiology concerned to link with schizophrenia are socio cultural factors in vein are poverty, conjugated housing accommodations, inadequate nutrition, absence of prenatal care, stress full situation and life style change.

The definite statistics is difficult to find because of the nature of schizophrenia but every place in the globe have people affected with schizophrenia. Some of the statistics data represents that, 3% of Australians are affected with psychotic disorder among them 1:100 Australians will experience schizophrenia (Australian bureau statistics, 2001). U.S population has 1.2 % of schizophrenia affected people (Dr .Hare, 1956). In India 7 million persons are affected with schizophrenia (Desh, 2011). Schizophrenia is the eighth leading cause of disability adjusted life years in the age group of 15-44 years worldwide. Therefore, it is understandable schizophrenia is imposing a very heavy burden on public health services.

Social skills are any skills facilitating interaction and communication with others. Social rules and relations are created, communicated, and changed in verbal and non verbal ways. The process of learning such skills is called socialization. Social skills training uses the principles of behavior therapy to teach communication skills, assertiveness skills, and other skills related to disease management and independent living. The rationale for this approach to treatment is that people meet a variety of social problems and can reduce the stress and punishments from the encounter as well as increase their reinforcement by having the correct skills.

Townsend 2009 describes that social skills training is an educational opportunity through Role play for the person with schizophrenia to learn appropriate social interaction skills and functional skills that are relevant to daily living. The treatment strategy of schizophrenia is highly heterogeneous that is no single treatment that cures the disorder. Instead effective treatment requires multidisciplinary effort including pharmacotherapy and various forms of psychosocial care, such as living skills, social skills training rehabilitation and family therapy.

The mental image of the schizophrenia among general public continues to improve. Also they have the awareness about the treatment and the prognosis aspect of schizophrenia that is there is no cure for this disorder but the treatment works well are available for their normal functioning which is enough to lead an independent, satisfying life. Several hypotheses were tested to relate the frequency of mental disorders to social conditions, none has been more persistently enunciated than that which proposes that schizophrenia is the outgrowth of social isolation. Schizophrenia is found in areas of city characterized by high residential mobility and low social economic status and among

foreign – born population of the slums. All of these indices were regarded as reflecting tendencies toward the social isolation of certain segment of population. This suggests that “any form of isolation that cuts the person off from intimate social relations for an extended period of time may possibly lead to this form of mental disorder (Han et al., 2004).

A study conducted by Jill (1999) to find the independency of flat effect and social skills in schizophrenic clients, result of this study showed that social skills were not significantly correlated with flat effect hence suggesting that the two constructs represents independent domains of functioning in schizophrenia.

Hence researcher assumes that social skills are defending dynamic model for schizophrenia. These social skills training promote the social skills and proficiency of the clients with schizophrenia. Hence they can compensate the areas of cognition, stressful events, neurobiological imbalance, social maladjustment, communication which helps to maintain the good relationship with the co persons and these factors promotion will inversely helps the individuals with schizophrenia not only in the relapse of the disorder but also flexibility, self support, inter personal support, and overall quality of the life improvement is attained. The fact is when the individuals are trained with the effective utilization of the skills in the daily life they are tend to be well good enough in problem solving, dealing with stressful events, and to face the challenges in the hectic life which all are the preventive factors for relapse.

Youngsters with the poor social skills-non conducive environment means parental over protectiveness also causes low social competency. Hence social skills training

program with high intensity and adequate duration will improve the efficiency among the schizophrenic client. Individuals with higher social skills will be promoted well when they are reinforced from the environment in the positive aspect that promotes social function among the schizophrenic clients. Even though social skills training are very beneficial in the promotion of social skills among schizophrenic clients there is paucity of research in this area especially in nursing. Thus the investigator is interested to assess the effectiveness of social skills training program among schizophrenic clients.

Statement of the Problem

A Quasi Experimental Study to Assess the Effectiveness of Social Skills Training Program Upon Social Skills Among Schizophrenic Clients in Selected Mental Hospitals at Chennai.

Objectives of the study

1. To assess the level of social skills in the control and experimental group of the schizophrenic clients before and after social skills training program.
2. To evaluate the effectiveness of social skills training by comparing the level of social skills in the control and experimental group of schizophrenic clients before and after Social skills training program.
3. To determine the level of satisfaction regarding social skills training program among experimental group of schizophrenic clients.

4. To find out the association between level of social skills and selected demographic variables in the control and experimental group of schizophrenic clients before and after Social skills training program.
5. To find out the association between level of social skills and selected clinical variables in the control and experimental group of schizophrenic clients before and after Social skills training program.

Operational Definitions

Effectiveness

The term effectiveness in this study referred to the increase in the level of social skills among schizophrenic clients after conducting the social skills training program as measured by NIMHANS social skills questionnaire.

Social skills training program

Social skills training program in this study is designed by the researcher based on the literature review and experts opinion for five consecutive days in a week, 90 minutes / day. Training program focuses on interpersonal domain and domain of coping with illness such as basic conversation, assertiveness, problem solving and medication management, relapse prevention, stress management and relaxation techniques by using various methods such as lecture cum discussion using power point, role play, group discussion and video shows (details given in the appendix).

Social skills

Social skills in this study are domains of interpersonal skills like basic conversation, assertiveness, problem solving and domain of coping with illness like medication management, relaxation, and prevention of relapse.

Schizophrenia

It is a psychiatric disorder characterized by the disturbance of thought, cognitive deficit, and suspiciousness, affect disturbances in clients and diagnosed to have schizophrenia by psychiatrist.

Schizophrenic clients

In this study schizophrenic clients are persons who suffer from schizophrenia and admitted for the treatment in selected mental hospitals.

Mental hospitals

In this study mental hospitals are the place where the schizophrenic clients reside to take treatment.

Assumptions

- Schizophrenic clients are usually impaired in social interactions.
- Social skills are important to lead a productive life.
- Social skills are protective model for schizophrenia.
- Social skills are learned behavior from childhood to adolescents.
- Nurses play vital role in improving social skills of the schizophrenic clients.

Null Hypothesis

- H₀₁** There will be no significant difference in the level of social skills of control and experimental group of schizophrenic clients before and after social skills training program.
- H₀₂** There will be no significant association between the level of social skills and the selected demographic variables before and after social skills training program in the control and experimental group of schizophrenic clients.
- H₀₃** There will be no significant association between the level of social skills and the selected clinical variables before and after social skills training program in the control and experimental group of schizophrenic clients.

Delimitations

- The study was limited to clients who have schizophrenia disorder at least for six months
- The study was limited to clients who were admitted and getting treatment at Doctor Peter Fernandez Home for Schizophrenia and Asha Rehabilitation Centre for Psychiatric Clients at the time of data collection.
- The study period was limited to six weeks of duration.

Conceptual Framework of the Study

The conceptual framework deals with inter related concepts that are assembled together in some rational schemes by virtue of their relevance to a common theme (Polit & Beck, 2004).

The conceptual framework of the study is based on Albert Bandura Social Learning Theory.

Bandura says that one's environment causes one's behavior. He suggested that environment causes behavior true; but behavior causes environment as well. He labeled this concept

Reciprocal determinism

The world and a person's behavior cause each other. Later, he went a step further. He began to look at personality as an interaction among three "things:" the environment, behavior, and the person's psychological processes. These psychological processes consist of our ability to entertain images in our minds, and language. And the behavior can be changed through modeling.

Attention

Attention involves characteristics of the model. If the model is attractive, or prestigious, or appears to be particularly competent, we will pay more attention. And if the model seems more like yourself, you pay more attention.

Conceptual frame work of the present study assumes that the nurse researcher can act as a prestigious model during the course of social skills training program in a way to influence the schizophrenic clients to pay attention and to imitate the nurse researcher to be a successive individual in the society. If they gain rewards during the process of imitation from the society, the client continue imitate the successive behavior in future to get reward, at the same time he act as the impressive model for the other clients.

Retention

The clients must retain details in which they paid attention.

In this study the nurse researcher assumes that the clients who involved in the social skills training program can retain the various skills learned in the social skills training program that may beneficial to improve their prognosis, prevent relapse, social relationships, manage stress and make their career success independently. On the other hand the client will experience their need to learn about social skills and ways to put into practice. In this way they create a imagery and language from what they have learnt during the social skills training program through mental images and verbal descriptions. When it's stored, they can later "bring up" the image or description, so that they can reproduce it with their own behavior.

Reproduction

Translate the images or descriptions into actual behavior.

In this study the nurse researcher helps the clients to bring up the images and description following the retention through role play and problem solving, group discussion because imitation of the behavior improves reproduction in practice as well

the audience improves reproduction through imagination. Because all will imagine their performance before the actual act that helps in successful reproduction of practice.

Motivation

Motivate to imitate until they reach the success in doing it.

In this study the nurse researcher did motivation through positive reinforcement, promised reinforcements (incentives), also imaginative and self promised reinforcement, and vicarious reinforcement (seeing and recalling the reinforced behavior).

Self-regulation

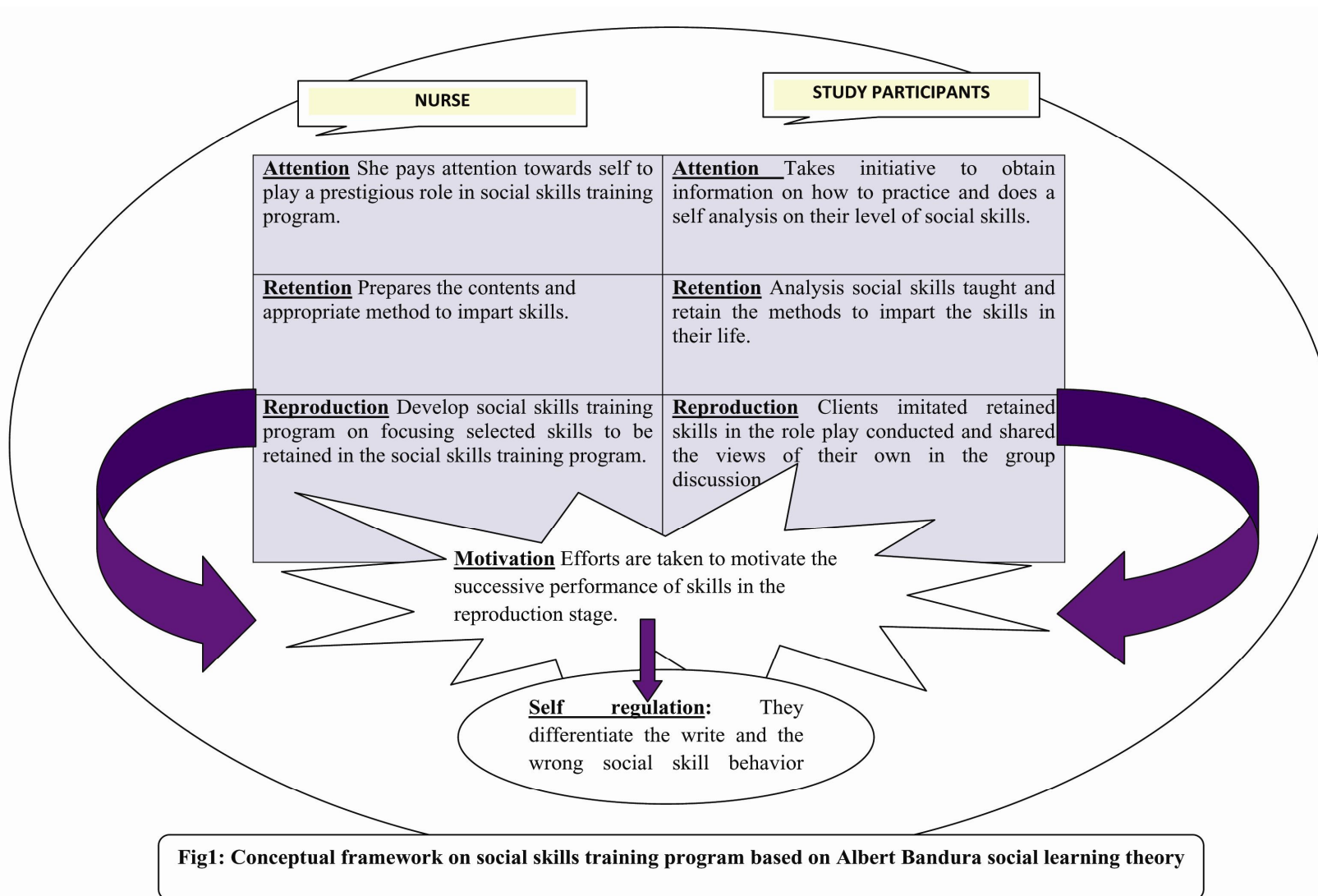
Controlling our own behavior –Is the other “workhorse” of human personality.

Motivation leads to self regulation where the nurse researcher suggests three steps.

Self-observation- Helps to keep tabs on the own behaviors.

Judgment- Compare with the standards thoughts to do their activities in order to battle the society.

Self-response- If they did well in comparison with the standard thoughts, researcher promoted the client to give self reward as self-responses.



Projected Outcome

Social skills training program enhance the social skills of schizophrenic clients. In turn it will help them to maintain healthy human relationship, be assertive, able to solve the problems in a healthy way. It will help in building an effective self medication management, stress management and to acquire good relaxation technique which will directly influence prognosis and reduce the relapse rate.

Summary

This chapter has dealt with the background, need for the study and statement of the problem, objectives, operational definitions, assumptions, null Hypothesis, delimitations and conceptual frame work.

Organization of the Report

Further aspects of the study are presented in the following five chapters;

In Chapter – II: Review of literature

In Chapter – III: Research methodology – which includes research approach, design, setting, population, sample and sampling techniques, tool description, content validity and reliability of tools, pilot study, data collection procedure and plan for data analysis.

In Chapter – IV: Analysis and interpretation of data

In Chapter – V: Discussion

In Chapter – VI: Summary, conclusion, implications and recommendations

CHAPTER - II

REVIEW OF LITERATURE

A literature is an organized written presentation of what has been published on a topic by scholars (Polit & Beck, 2010).

The task of reviewing literature involves the identification, selection, critical analysis and reporting of existing information on the topic of interest. This chapter deals with review of published research studies, unpublished research studies and from related material for the present study. The review helped the researcher in building the foundation of the study.

The review of literature is presented under the following headings.

- I. Literature related to of schizophrenia.
- II. Literature related to schizophrenia psychosocial interventions.
- III. Literature related to effectiveness of social skills training program.
- IV. Literature related to schizophrenia and social skills training program.

I. Literature related to schizophrenia

A study to assess the subjective burden on spouses of schizophrenia patients at the OPD of RINPAS (Ranchi institute of neuropsychiatry and sciences) the result of this study findings suggest that both male and female spouses of schizophrenic clients have moderate level of subjective burden that is 52% of male spouses and 60% of female spouses .which was found to be statistically significant (Kumari et al., 2009).

Recent systematic reviews have encouraged the psychiatric research community to reevaluate the contours of schizophrenia epidemiology. This paper provides a concise overview of three related systematic reviews on the incidence, prevalence, and mortality associated with schizophrenia. The incidence of schizophrenia shows prominent variation between sites. The median incidence of schizophrenia was 15.2/100,000 persons, and the central 80% of estimates varied over a fivefold range. The rate ratio for males and female was 4:1. Prevalence estimates also show prominent variation.

The median lifetime morbid risk for schizophrenia was 7.2/1,000 persons. On the basis of the standardized mortality ratio, people with schizophrenia have a two- to threefold increased risk of dying and this differential gap in mortality has increased over recent decades. Compared with native-born individuals, migrants have an increased incidence and prevalence of schizophrenia. Exposures related to urban city, economic status, and latitude are also associated with various frequency measures (Grath et al., 2008).

Sukanta et al., in 2004 done a systemic review on hundred core studies, 24 migrant studies, 23 cohort studies, and 14 studies based on other special groups and these studies were generally drawn from 33 countries these study findings indicate that the distribution rate is 15.2 / 100,000 and the distribution rates was significantly higher in males than in females. The distribution rates in migrants were significantly higher compared to native born.

II. Literature related to schizophrenia psychosocial interventions

Meta analysis is done for the studies the studies included in the Meta analysis were group education for family members. Compliance with medication was significantly improved in a single study using brief group intervention (at one year) but other studies produced equivocal or skewed data. Any kind of psycho educational intervention significantly decreased relapse or readmission rate. Several of the secondary outcomes like knowledge gains, mental state, and global level of functioning, status of high expressed emotion family members were measured using scales that are difficult to interpret. However, findings were consistent with the possibility that psycho education has a positive effect on a persons' well being (Pekkala, 2011).

A study conducted for two years to find the effects of psycho social treatment on the brain of schizophrenia among individuals with early course of schizophrenia the results of this study demonstrated that Individuals receiving CET (cognitive enhancement therapy) demonstrated significantly greater preservation of gray matter volume over the course of two years in the left hippocampus, Para hippocampus gyrus, and fusiform gyrus, and significantly greater gray matter growth in the left amygdala.

Compared with the individuals those receiving EST (enriched supportive therapy). All of these areas of the brain have been previously implicated in cognitive impairment in schizophrenia, and results from a series of growth models indicated that less gray matter loss in the left parahippocampal and fusiform gyrus, and greater gray matter increases in the left amygdala were significantly related to improved cognition and mediated the previously reported beneficial cognitive effects of CET (Salson, 2011).

III. Literature review related to effectiveness of social skill training

The literature dealing with social skills training says that Research must be directed to determining the interaction between patient characteristics and training procedures as they affect outcome. The scope of the procedures must also be expanded if meaningful changes in patients' quality of life are to be effected.

Social skills training for children aged between 5 and 18 with Attention Deficit Hyperactivity Disorder (ADHD). Children with Attention Deficit Hyperactivity Disorder (ADHD) are hyperactive and impulsive, cannot maintain attention, and have difficulties with social interactions. This review looks at whether social skills training benefits children with ADHD. In this study Damm et al., 2011 found that structured social skills training program reduces the impulsive activity and made them to pay more attention in their activities.

A study conducted by department of psychiatry in university of California to assess the effectiveness of social skills training for young adults with high functioning Autism Spectrum disorder. Research results suggested that treated young adults reported significantly less loneliness and improved social skills knowledge, while the care giver reported significant improvements in young adults over all social skills (Man, 2011).

Children with prenatal alcohol exposure (PAE) have significant social skills deficit and are often treated in community mental health settings However, it remains unclear whether these children can be effectively treated using manualized, evidence-based interventions that have been designed for more general mental health populations. To shed light on this issue, the effectiveness of Children's Friendship Training (CFT)

versus Standard of Care (SOC) was assessed for 85 children ages 6 to 12 years with and without PAE in a community mental health center. This study finding indicates that Children who participated in CFT showed significantly improved knowledge of appropriate social skills, improved self-concept, and improvements in parent-reported social skills compared to children in the SOC condition also suggested CFT as the evidence based practice (Mary et al., 2011).

A study conducted among school students on Explicitly Teaching Social Skills Using a Matrix to Guide Instruction. This study finding indicates that socially skilled students are more successful in school. Just like academic skills, social skills need to be explicitly taught. Students, including students who display at-risk behavior, benefit when social skills instruction is delivered school wide as part of a comprehensive intervention approach (Simson et al., 2011).

A Pilot Study conducted by Kim et al., 2011 to find the Effects of Social Skills Training vs. Psycho education on Negative Attitudes of Mothers of Persons with Schizophrenia. In this study 15 mother with strong negative feelings towards the schizophrenic son were assigned by convenience from outpatient clinic to participate in this study the mothers in the social skills training group demonstrated significantly reduction in negative attitudes that were sustained across all of the follow ups. Hence the study concluded that social skills' training is more effective than the psycho education in reducing the negative attitudes of parents who have an off spring with schizophrenia.

The paper presented in Ro-MAN 2011 IEEE reports on cross-collaborative efforts between computer science, special education and mechanical engineering on some of the robotic platforms used in therapeutic environments, and their investigation of using robots as educationally useful interventions to improve social interactions for individuals with Autism Spectrum Disorders (ASD). Development of a third generation robotic agent is described which uses an approach to treatment as an educational intervention based on Socially Assistive Robotics (SAR), direct instruction pedagogy, the use of social scripts, and their investigative process of using Lego® NXT platforms(Poulos et al., 2011).

Ayanzadeh (2003) conducted study to find the efficacy of social skills training on adjusting behaviors of mild mentally retarded children. The study findings showed that the experimental group had significantly in adjusting behaviors and social skills .the control group comparatively did not significant improve on the variables. Hence social skills training improve adjusting behaviors of mild mentally retarded child.

A study conducted among preschoolers, elementary and secondary level students with emotional and behavioral problems to examine the effectiveness of social skills intervention. This review indicates that social skills instruction could enhance social interaction skills however many social skills interventions were only mildly effective for preschoolers and students maintained their social skills across time (Quinn et al., 1999).

Fifty three studies were Meta analyzed; the studies are taken from past 15 years on social skills training for children with learning disabilities (LDs). Although social skills deficits seem to be characteristic of children with LDs, such deficits appear highly

resistant to treatment. Across the 53 studies analyzed, the training mean effect size obtained was only .211, with very few differences among teachers, peers, or children who judged effectiveness of training. Children with LDs seemed the most impressed with their social skills after training. However, peers without LDs tended to view the same results as significantly less positive. Teacher impressions were modest regarding the impact of training on overall social adjustment and almost negligible regarding intervention for such problems as conduct disorders or hyperactivity. Among all 3 groups, actual social interaction was rated among the least improved skills (Kavale & Forness 1995).

IV. Literature related to social skills training for schizophrenia

A randomized controlled trial included middle aged and older patients with chronic schizophrenia to assess the cognitive behavioral social skills training. The study findings indicate that the patients received combined treatment performed social functioning activities significantly more frequently than the patients in the usual treatment. But the patient received cognitive behavioral social skills training achieved greater cognitive insight indicating more objectivity in reappraising psychotic symptoms, and demonstrated greater skill mastery (Granholm et al., 2005).

A prospective study conducted based on the vocational skills training developed in Hong Kong for people affected by chronic schizophrenia in this study participants assigned to three groups as a social skills training group with follow up, a social skills training group without follow up support, and a comparison group who received standard after care treatment. The study findings reports that participants in the training group statistically over performed than the comparison group and those

receiving the training plus follow up were much more successful in finding and keeping a job than the participants in of the other two groups (Tsang, 2001).

A pilot study conducted by Kopelowicz et al., 1998 in order to Compare the Efficacy of Social Skills Training for Deficit and Nondeficit Negative Symptoms in Schizophrenia who did or did not have the deficit syndrome. Three subjects with the deficit syndrome and 3 with nondeficit negative symptoms received 12 weeks of social skills training. Social skills and negative symptoms were evaluated before and after training and at 6-month follow-up. Patients with schizophrenia who did not have the deficit syndrome demonstrated significantly better social skills and lower negative symptoms both after training and at follow-up than did those who had the deficit syndrome. Schizophrenic patients with Non deficit negative symptoms appear amenable to intensive social skills training, but schizophrenic patients with the deficit syndrome may have significant deficits in skill acquisition.

Community based study to incorporate social skills training in the community because majority of treatment for schizophrenia has become community based hence in 1991, Honey et al., assessed the barrier faced by many clients as they attempt a higher quality of life is social integration. Social skill deficits are a pervasive developmental issue among this population, yet this has only been addressed peripherally as opposed to intensively in existing community rehabilitation programs. The authors outline the developmental social deficits resulting from the insidious nature of schizophrenia and propose a comprehensive treatment program that focuses on identify, train and support approach. Transferring successful inpatient social skill training to the community is explored as a viable adjunct for existing community treatment.

Summary

This chapter dealt with the literature allied with the schizophrenia, schizophrenia psychosocial intervention, effectiveness of social skills training program, and literature related to schizophrenia and social skills training program. This review of literature highlights the need and importance of social skills to maintain the independent life and successful life. The above mentioned literatures reviews have been derived from various primary and secondary sources in these 15 counts are retrieved from primary sources and 3counts are retrieved from secondary sources. It has also enabled the researcher to design the study, develop the tools, and plan the data collection procedure to analyze the data.

CHAPTER - III

RESEARCH METHODOLOGY

The methodology of the research study is defined as the way data are gathered in order to answer the research questions or analyze research problem. Research methodology involves a systematic procedure by which the researcher starts from the initial identification of the problem to its final conclusion. The present study was conducted to assess the effectiveness of social skills training program among the schizophrenic clients to enhance the level of social skills at Asha Psychiatric Home, West Tambaram, Chennai.

This chapter deals with a brief description of different steps undertaken by the investigator for the study. It includes research approach, setting, population, and sample, and sampling technique, selection of tool, content validity, reliability, pilot study, and data collection procedure and data analysis.

Research Approach

Research approach is the most significant part of any research. The appropriate choice of research approach depends on the purpose of the research study which is undertaken. According to Polit & Beck (2010), experimental research is an extremely applied form of research and involves in finding out how well a program, practice, or policy is working. Its goal is to assess or evaluate the success of the program.

An experimental research is generally applied where the primary objective is to determine the extent to which a given procedure meets the desired result. In this study as the researcher wanted to assess the effectiveness of social skills training program among the schizophrenic clients, the experimental approach was chosen to conduct this study.

Research Design

The research incorporates the most important methodological design that a researcher works in conducting a research study (Polit & Beck 2010).

The research design used in this study is quasi experimental design - two group pretest, post test design with treatment. In this study, the investigator administered pre test to assess the level of social skills among both experimental and control group and manipulated independent variable i.e. social skills training program which was conducted to the experimental group. Then the post test was conducted to both experimental and the control group study clients to assess the effectiveness of social skills training program.

Then the level of satisfaction was assessed using rating scale among experimental study clients. The research design is represented diagrammatically as follows

O1 - O2

O1 X O2

O1 – Pre test

O2- Post test

X – Social skills training program.

Intervention

It is a 6 weeks training program which mainly focused on improvement of level of social skills among schizophrenic clients.

The social skills Training program is designed on various aspects such as basic conversation skill, assertiveness, problem solving ,medication management, relapse prevention ,stress management ,relaxation technique by using various methods such as lecture cum discussion using power points, role play , video show and group discussions. The session was conducted in week days between 9 am to 10.30 am.

The researcher introduced the domains included in the study like basic conversation, assertiveness, problem solving, medication management, and relaxation techniques, measures to prevent relapse also insisted about the techniques used in this study to teach this domains in the first week. In the second week of the study basic conversation skills and techniques of communication was taught to the clients through teaching strategy, followed by the group discussion among the participants in order to encounter the problem of the clients in the process of communication and the doubts of the clients related to the communication problems are clarified were as role play was conducted to enhance the communication techniques in real practice.

The researcher dealt with the assertiveness, problem solving techniques in third week of the session. Role play was conducted and situation analysis was done among group, self problem analysis was in order to generate the self solution to solve the

obstacles of their own, quiz was conducted to assess the assertiveness. The fourth is about the self medication management which comprises habits to be deleted and habits to be added which promotes the medication effects, side effects of medication and their management, drug compliance. Group discussion was conducted to assess the knowledge status of the clients.

The fifth week is the relaxation week, this session starts with the assessment of the relaxation methods practiced by the clients when they feel stressed .Then the researcher taught some of the useful techniques that can be practiced with the available basic facilities in all the places through power point presentation .The techniques taught are breathing exercise, listening to music, physical exercises like walking. The video sessions were arranged by the researcher to listen music and videos of comedy movies are played.

Measures to be followed to prevent relapse are taught in the last week it includes various stress management techniques, importance of lifelong medications and doctor consultation, educated to avoid street drugs, and educated about the warning symptoms and management. Group discussion was arranged to assess the knowledge. Ice breaking sessions were also conducted between the sessions to prevent monotony of the program. (These details are given in appendix).

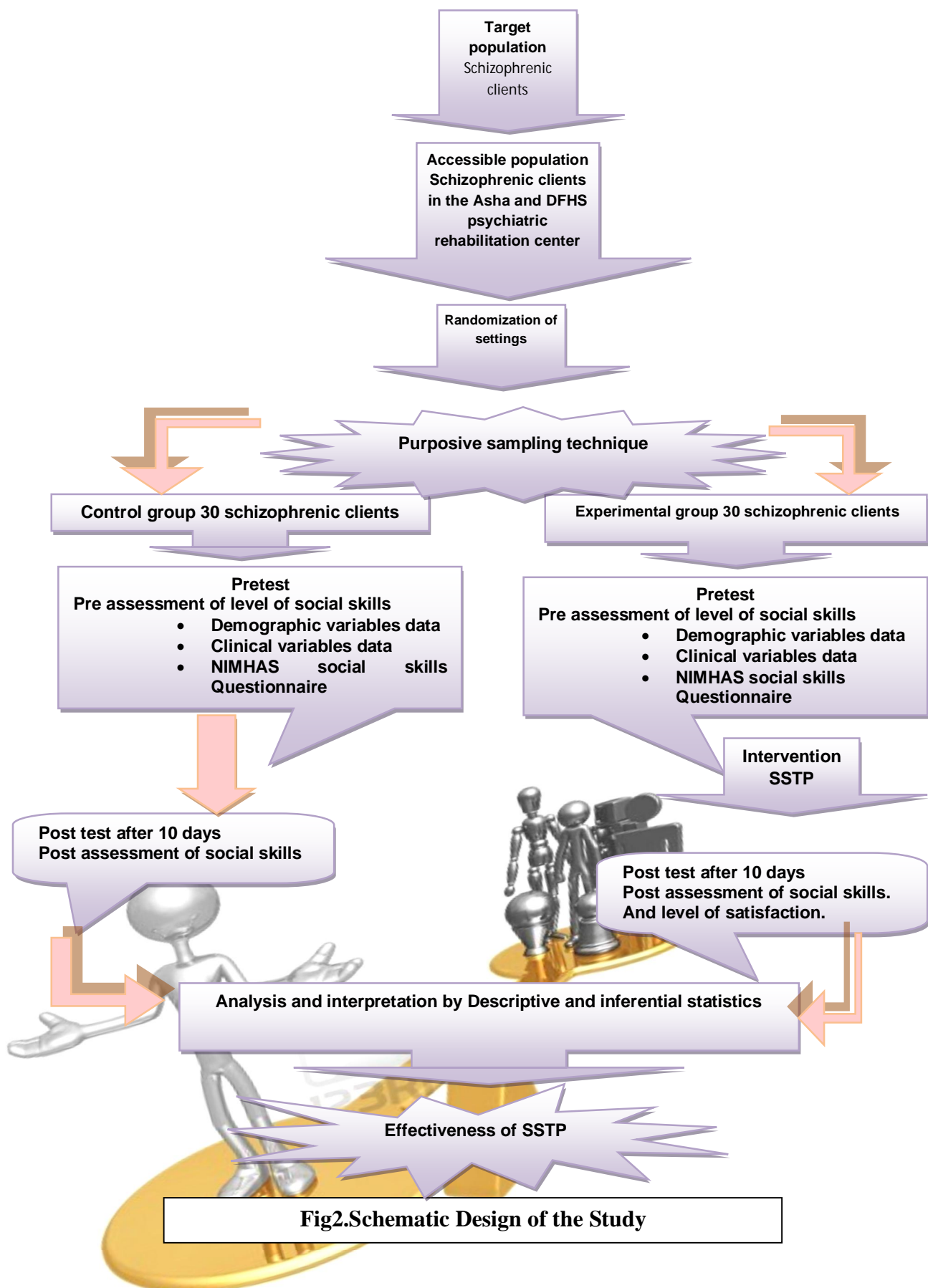


Fig2.Schematic Design of the Study

Variables

An abstract concept that can be measured in a study is called a variable. Variables are characteristics that vary among the subject being studied.

Independent variable

The independent variable of the study is social skills training program.

Dependent variable

The dependent variable of the study is level of social skills among schizophrenic clients.

Attribute variable

It included the demographic and the clinical variables which had an influence on the social skills of the schizophrenic clients.

Research Setting

Settings are the most specific places where data collection was takes place (Polit & Beck 2010).

The present study was conducted at Doctor Peter Fernandez Home for Schizophrenia, is located in mugalivakam, Chennai. About 10 kms from the main bus stand. It is a 60 bedded home and Asha psychiatric rehabilitation center for schizophrenic clients is located in west Tambaram, Chennai. About 15 kms from the main bus stand. It's a 60 bedded psychiatric hospital

Most of the clients in these centers are visited by their guardians and are also taken home during festivals and other occasions, but the family members do not stay with the clients. Few clients come for day care. The inmates have a daily schedule of activities starting from morning prayer, exercises, games, breakfast, paper cover making, therapy sessions followed by lunch and a period of rest. Evening walks in the nearby park is followed by watching television, dinner and bedtime. There is full time nurse and a social worker working in morning shifts.

Population

Population is the entire aggregation of cases who meet the designated set off criteria (Polit & Beck, 2010).

Target population

Target population is the group of population, that the researcher is aimed to study and to whom the study findings will be generalized. In this study target population was schizophrenic clients.

Accessible population

Accessible population in this study was clients with Schizophrenia who meet the inclusion criteria at Doctor Peter Fernandez Home for Schizophrenia, at Mugalivakam, Chennai and Asha Rehabilitation Center for Schizophrenic Clients at West Tambaram, Chennai.

Sample

Sample consists of the subset of the population (Polit & Beck, 2010).

A sample of 60 clients were included in the study who met the inclusion criteria at Doctor Peter Fernandez Home for Schizophrenia, at Mugalivakam, Chennai and Asha rehabilitation center for schizophrenic clients at west Tambaram, Chennai.

Thirty clients in control group were selected from Doctor Fernandez Home for Schizophrenia and 30 clients in experimental group were selected from Asha Rehabilitation Centre for Schizophrenic Clients.

Sampling Technique

Sampling referred to the process of selecting a portion of the population to represent the entire population (Polit & Beck, 2010).

Randomization of the settings was done. From the selected settings samples were chosen by purposive sampling technique. It is a non-probability sampling technique in which the researcher selected participants based on the inclusion criteria of the study.

Sampling Criteria

Inclusion criteria

- Clients' who are admitted and getting treatment for at least past one month in the selected psychiatric hospital.
- Clients' who are suffering from schizophrenia for at least past six months.

Exclusion criteria

- Clients' who are not willing to participate.
- Clients who have acute symptoms.
- Clients' who are very aggressive.
- Clients' who are not co-operative.

Selection and Development of Study Instruments

As the study aimed to evaluate the effectiveness of social skills training program upon social skills, the data collection instruments were developed and chosen through an extensive review of literature in consultation with experts and with the opinion of faculty members. The instruments used in this study were Demographic variables Proforma, Clinical variables Proforma, NIMHANS social skills questionnaire and rating scale on the level of satisfaction on social skills training program.

Demographic variables proforma of schizophrenic clients

The Demographic variables Proforma was used to collect the base line details such as age, educational status, occupational status, type of family, family income, number of family members, marital status, and number of children, and duration of stay. The investigator collected the data by interviewing the patient.

Clinical variables proforma of schizophrenic clients

This was used to assess the clinical variables such as diagnosis, duration of illness, history of previous hospitalization, sources of help availed, family history of

mental illness, if family history was present, then relationship of that person to the client, history of violent behavior and interval between onset of illness and treatment initiation. The investigator collected the data by interviewing the client and referring the case sheet of the client.

Social skill questionnaire

The 12-items standardized social skill questionnaire used in NIMHANS to assess the level of social skills was used in this study.

The tool consists of three subscales

- Patients self report - 1, 2,3, 4, 5

[5 items, obtainable score 5- 20]
- Researcher observation
 during interview – 6, 7, 8, 9,10,11

[6 items, obtainable score 6-24]
- Other information -12,

[1 item, obtainable score 1- 4]

Thus the total obtainable scores are 12-48.

Scoring is interpreted as follows:

S.no	Scores	Percentage	Interpretation
1.	<12	<25%	Very low level of social skills
2.	12-24	26 – 50%	Low level of social skills
3.	25-35	51- 75%	Moderate level of social skills.
4.	>35	>75%	High level of social skills

Higher the score better the social skills.

Rating scale on level of satisfaction on social skills training program

This scale is developed by the researcher based on the objectives of this study. This scale consists of 10 items on satisfaction of the clients regarding various aspects of the social skills training. The scale is a 4 point Likert scale. The score ranges from 4 to 1 (Highly satisfied-4, Satisfied-3, Dissatisfied-2, highly dissatisfied-1). The scale was used to assess the explanation given about the social skill training program, the researcher's approach to the clients, the time duration, understandability and usefulness, involvement of participants in the programme, use of audio visual aids, involvement of the participants, and the arrangements made during the programme.

The total obtainable score of this scale is 10-40

Scoring is interpreted as follows:

Scoring	Interpretation
76%-100%	Highly Satisfied.
51-75%	Satisfied.
25-50%	Dissatisfied.
Below 25%	highly dissatisfied.

Psychometric Properties of Instruments

Validity

The content validity refers to the degree to which the item on an instrument adequately represents the universe of the content (Polit & Beck, 2010).

Social skills questionnaire is a standardized instrument. The other Proforma and scales were validated and certified by seven experts. The modifications and suggestions of experts were incorporated in the final preparation of the tool.

Reliability

I NIMHANS - Social skill questionnaire

Reliability refers to the accuracy and consistency of measuring tool. Reliability score of social skills tool is 0.92. The reliability of the translated version in Tamil is established by split half method and the reliability score was 0.88.

II Rating scale for assessing satisfaction on social skills training program among experimental group of Schizophrenic clients

Reliability refers to the accuracy and consistency of measuring tool. The level of satisfaction scale was tested using split half method and the reliability was found to be 0.79 which indicates that the tool is highly reliable. The satisfaction scale was also certified by and validated by 7 experts.

Pilot Study

Pilot study is a miniature of some part of actual study, in which the instrument is administered to the subjects drawn from the same population. It is a small scale version done in preparation for a major study. (Polit & Beck, 2010). The purpose was to find out the feasibility and practicability of study design. A pilot study was conducted on ten schizophrenic clients and it was feasible to conduct the study.

The pilot study was conducted among 10 schizophrenic clients in Boaz Psychiatric Rehabilitation Center, East Tambaram and Asiana Rehabilitation Center, Nugambakam. Formal permission was obtained from the authorities of both the rehabilitation centers prior to pilot study. The subjects were chosen by purposive sampling technique, 5 in the experimental group and 5 in the control group. Social skills training program was given for 90 minutes a day for period of seven days to the experimental group. There was no intervention given for the control group of schizophrenic clients. The levels of social skills were assessed for both the control and experimental group after one week. Then the level of satisfaction on social skills training program were assessed using the rating scale for experimental group. The results of the pilot study revealed that the present study was feasible to conduct.

Human Rights

The study was conducted after the approval of ethical committee, Apollo hospitals Chennai. The study was conducted after obtaining permission from the principal Apollo College of Nursing, H.O.D psychiatric nursing department, concerned authority of the schizophrenia centers to conduct study, in Doctor Peter Fernandez Home for Schizophrenia, Mugalivakam, Chennai and Asha Rehabilitation Center for

Schizophrenic Clients, West Tambaram, Chennai. The written consent was obtained from the clients and confidentiality of the data was maintained throughout the study.

Data Collection Procedure

Data collection is the gathering of information needed for the researcher to address the research problem. Data collection was done by the researcher for a period of six weeks in the month of June and July. The settings were randomized to determine the experimental and control group. Researcher identified the client who meets the inclusion criteria and included 30 clients in each setting for the study through purposive sampling technique. After initial introduction, the researcher obtained consent from the clients to participate in the study. An assurance was given regarding confidentiality before the data collection procedure. The Data was collected by using the demographic variable Performa, clinical variable Performa, NIMHANS social skills questionnaire, and rating scale for the participants by interview, observation and self administration.

After the pre-test, the clients in the experimental group received social skills training program in addition to the treatment. The program held for 90 minutes in week days for 6weeks, by using different methods Lecture cum Discussion, Video Shows, Role-Plays, Group discussion. Finally all the session follows with the activities for practice like stress buster games, assertiveness quiz, group discussion and role play. The clients are also asked to discuss the problems in order to get the self solution for the problem.

The subjects in the control group were allowed to participate in all aspects of treatment and activities which was scheduled in the concern rehabilitation center. Post

test was conducted in both control and experimental group on the 40th day of the social skills training program by using NIMHANS social skills questionnaire.

Then the level of satisfaction regarding social skills training program was assessed using rating scale for level of satisfaction in the experimental group.

Problems Faced During Data Collection

The clients and the concerned authorities were very co operative and there were no problems during data collection and intervention.

Plan for Data Analysis

Data analysis is the systematic organization and synthesis of research data and testing of null Hypothesis by using the obtained data (Polit & Beck, 2010). Data was analyzed using appropriate descriptive and inferential statistics.

Descriptive statistics such as mean, median, frequency, standard deviation and the percentage were used to describe the demographic variables, clinical variables and the level of social skills in the control and experimental group schizophrenic clients.

Inferential statistics like independent 't' test were used to assess the effectiveness of social skills training program on social skills by comparing the pre and post test mean score of social skills.

Chi-square test was used to assess the association between level of social skills and the selected demographic variables and clinical variables of schizophrenic clients.

Summary

This chapter has dealt with research approach, research design, setting, population and sample, sampling technique, sampling criteria, selection and development of study instruments, validity, reliability, pilot study, data collection procedure and plan for data analysis. The following chapter will deal with analysis and interpretation of using descriptive and inferential statistics.

CHAPTER - IV

ANALYSIS AND INTERPRETATION

This chapter deals with the analysis and interpretation of data, the data was collected from 60 schizophrenic clients to assess the effectiveness of social skills training. The data was analyzed according to the objectives and hypothesis of the study. Data analysis was done manually after transferring the collected data into master coding sheet by the researcher using descriptive and inferential statistics.

Organization of Findings

The analysis of data was organized and presented under following headings,

- Frequency and percentage distribution of demographic variables in the control and experimental group of schizophrenic clients.
- Frequency and percentage distribution of clinical variables in the control and experimental group of schizophrenic clients.
- Frequency and Percentage Distribution of Level of Social Skills Before and After Social Skills Training Program in the Control and Experimental Group of Schizophrenic Clients.
- Frequency and percentage distribution of level satisfaction regarding social skills training program among experimental group of schizophrenic clients.

- Comparison of mean and standard deviation of social skills scores before and after social skills training program between the control and experimental group of schizophrenic clients.
- Association between the selected demographic variables and the level of social skills before and after social skills training program in control group of schizophrenic clients.
- Association between the selected demographic variables and the level of social skills before and after social skills training program in experimental group of schizophrenic clients.
- Association between the selected Clinical variables and the level of social skills before and after social skills training program in control group of schizophrenic clients.
- Association between the selected Clinical variables and the level of social skills before and after social skills training program in experimental group of schizophrenic clients.

Table 1

Frequency and Percentage Distribution of the Demographic Variables in the Control and the Experimental Group of Schizophrenic Clients

Demographic Variables	Control Group (n=30)		Experimental Group (n=30)	
	n	p	n	p
Age in years				
30-40	8	27	12	40
41-50	9	30	8	27
51-60	13	43	10	33
Gender				
Male	19	63	16	63
Female	11	37	11	37
Educational status				
Non literate	5	17	4	13
Primary school	5	17	3	10
Secondary	6	20	5	17
Higher secondary	6	20	8	27
Graduate and above	8	27	10	33
Monthly family income in rupees				
5000- 10000	19	63.3	17	57
11001-20000	4	13.3	8	27
21001-30000	7	23.3	5	17
Marital status				
Married	17	57	7	23
Unmarried	6	20	15	50
Separated	3	10	6	20
Widow/Widower	4	13	2	7
Religion				
Hindu	22	73	20	67
Muslim	3	10	5	17
Christian	5	17	5	17

It can be inferred from the table1 that most of the clients in this study were males (63%, 63%), Hindus (73%, 67%), with the family income between 5000-10,000/month (63.3%, 57%) in the control and experimental group respectively. Significant percentage of the clients belongs to joint family (53%, 47%), aged above 50 years (43%.33%), (20%, 50%) unmarried in the control and experimental group respectively.

Figure 3 shows that 43% of the clients were unemployed

Figure 4 shows that 43% of the clients were residing in urban area.

Figure 5 shows that 73% of the clients were from the nuclear type of family.

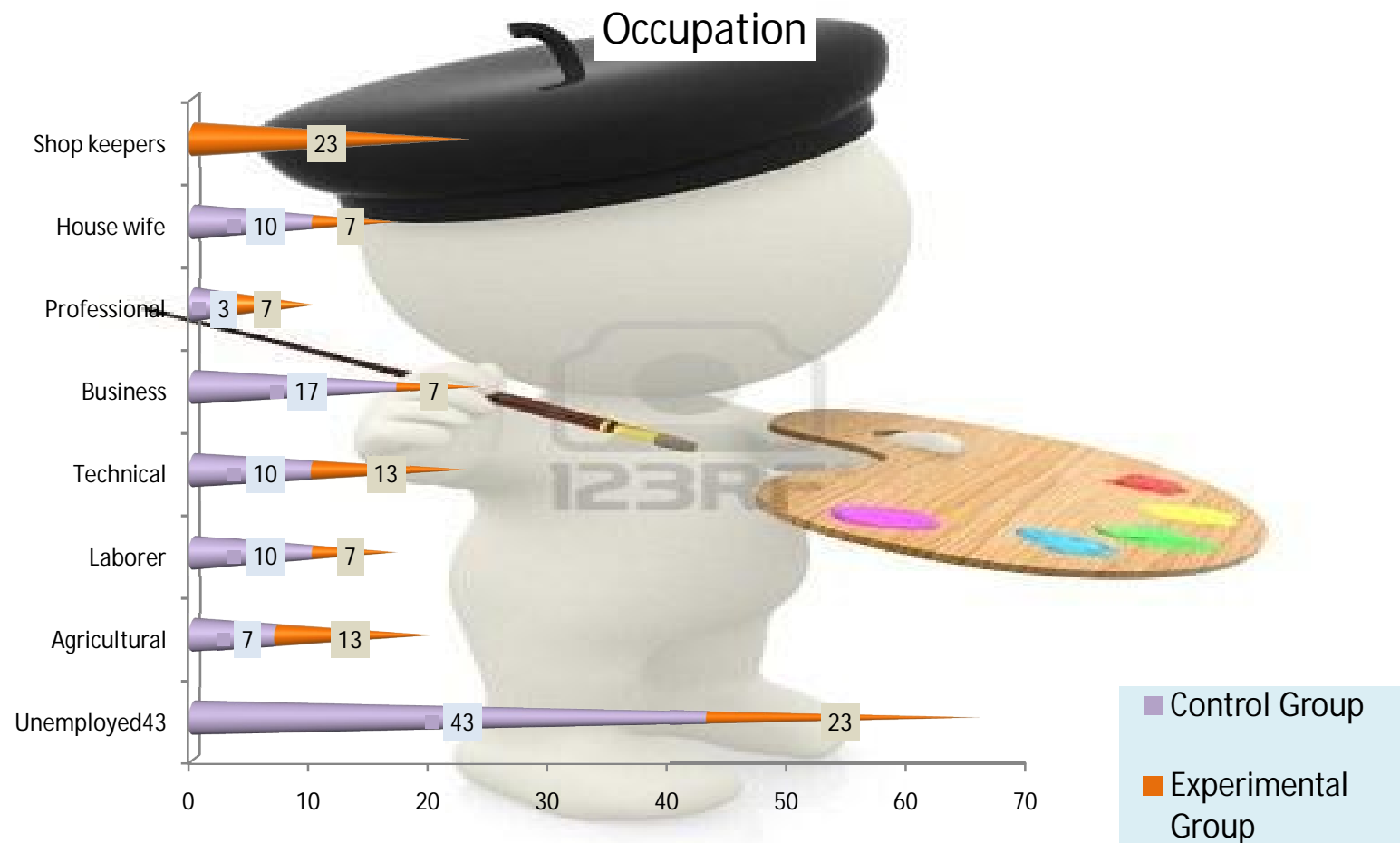


Fig3: Percentage Distribution of Occupation in the Control and Experimental Group of Schizophrenic Clients

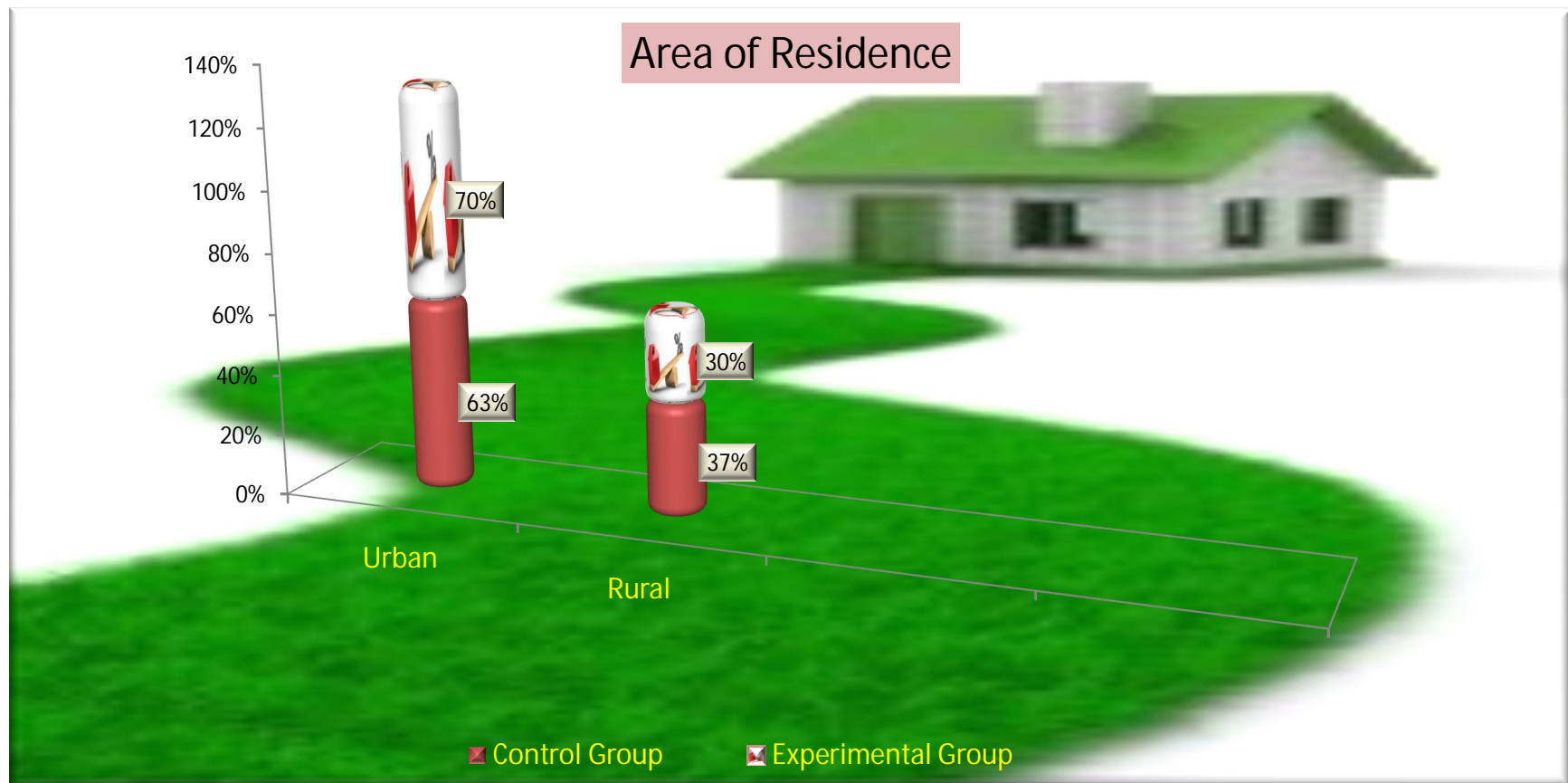


Fig4: Percentage Distribution of Area of Residence in the Control and Experimental Group of Schizophrenic Clients

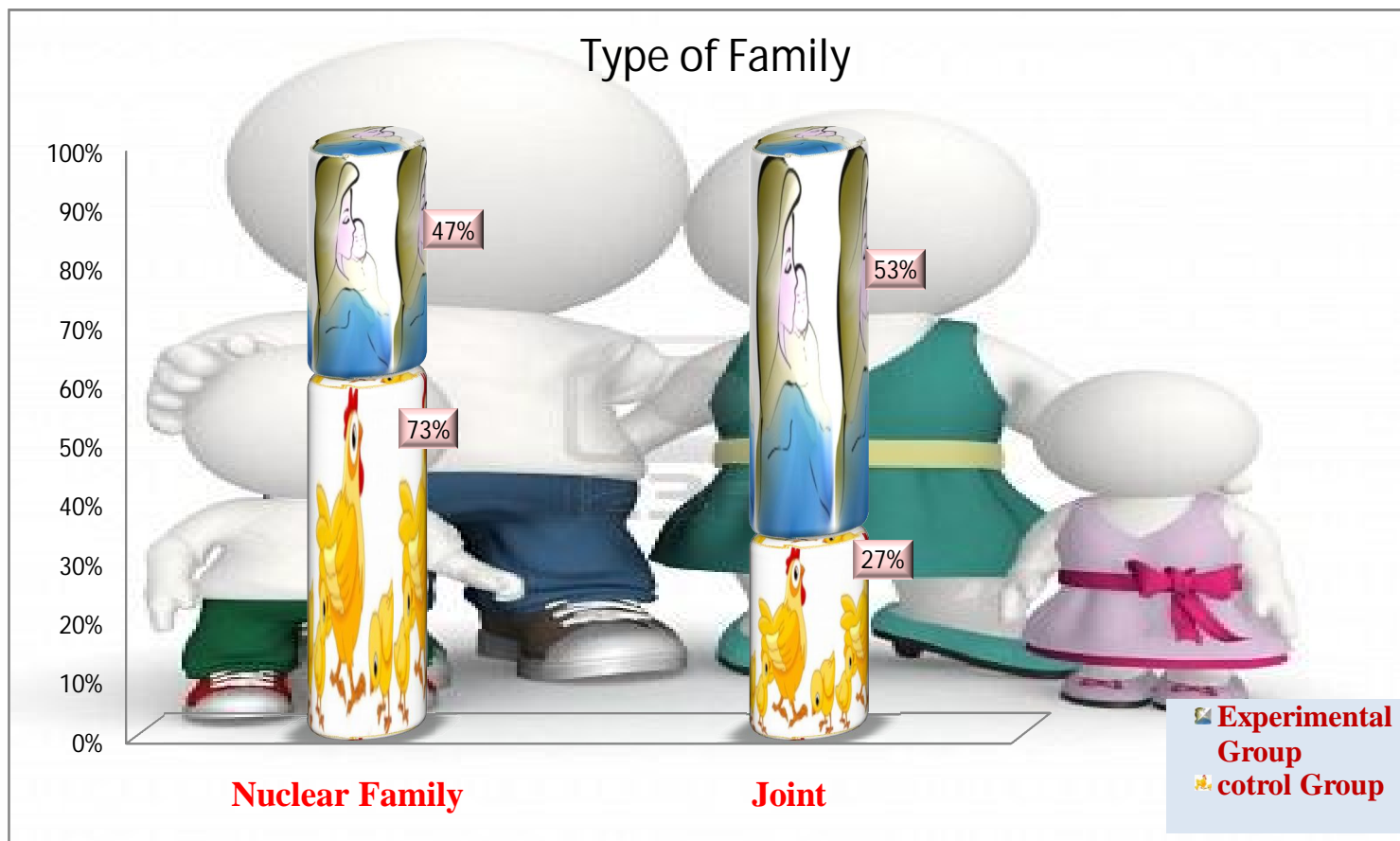


Fig5: Percentage Distribution of Type of Family in the Control and Experimental Group of Schizophrenic Clients

Table 2

Frequency and Percentage Distribution of the Clinical Variables in the Control and Experimental Group of Schizophrenic Clients.

Clinical Variables	Control Group (n=30)		Experimental Group (n=30)	
	n	p	n	P
Sources of help first sought by clients.				
Traditional Healing	3	10	3	10
Temple Priests	4	13.3	4	13.3
Churches	2	6.7	2	6.7
Mosques	1	3.3	1	3.3
Black magic	2	6.7	2	6.7
Exorcist	1	3.3	2	6.7
Medical facilities	11	36.7	8	26.7
Others	6	20	8	26.7
Family history of mental illness				
Present	18	60	20	66.7
Absent	12	40	10	33.3
If present relationship to the client				
First degree	11	36.7	16	53.3
Second degree	5	16.7	2	6.7
Third degree	1	3.3	2	6.7
Interval between onset of illness and treatment				
Immediately	16	53.3	14	46.7
Up to 1 year	5	16.7	7	23.3
>1 year	4	13.3	6	20
Don't know	5	16.7	4	13.3

It can be inferred from the table 2 that most of the study clients sought help from other traditional sources for their treatment (63.3%, 73.3%), have family history of mental illness (60%, 66.7%) and they are first degree relatives to the clients (36.7%, 53.3%) in control and experimental group respectively. Significant

percentage of the clients got treatment immediately after the onset of illness (53.3%, 46.7%) in control and experimental group respectively.

Figure 6 Shows that 83% of the clients have the previous history of hospitalization.

Figure 7 Shows that 53% of the clients have the history of violent behavior.

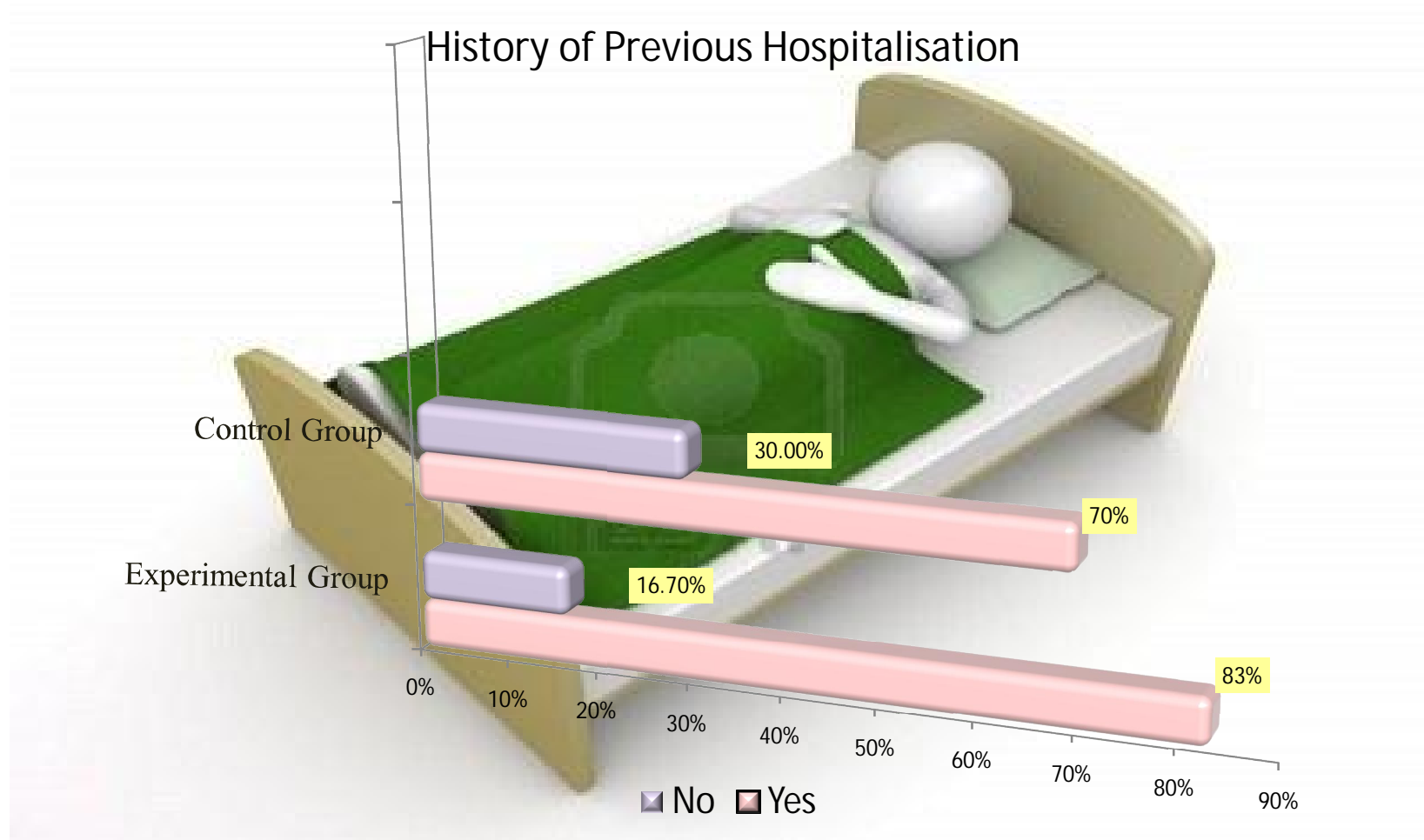


Fig6: Percentage Distribution of Previous Hospitalization in the Control and Experimental Group of Schizophrenic Clients

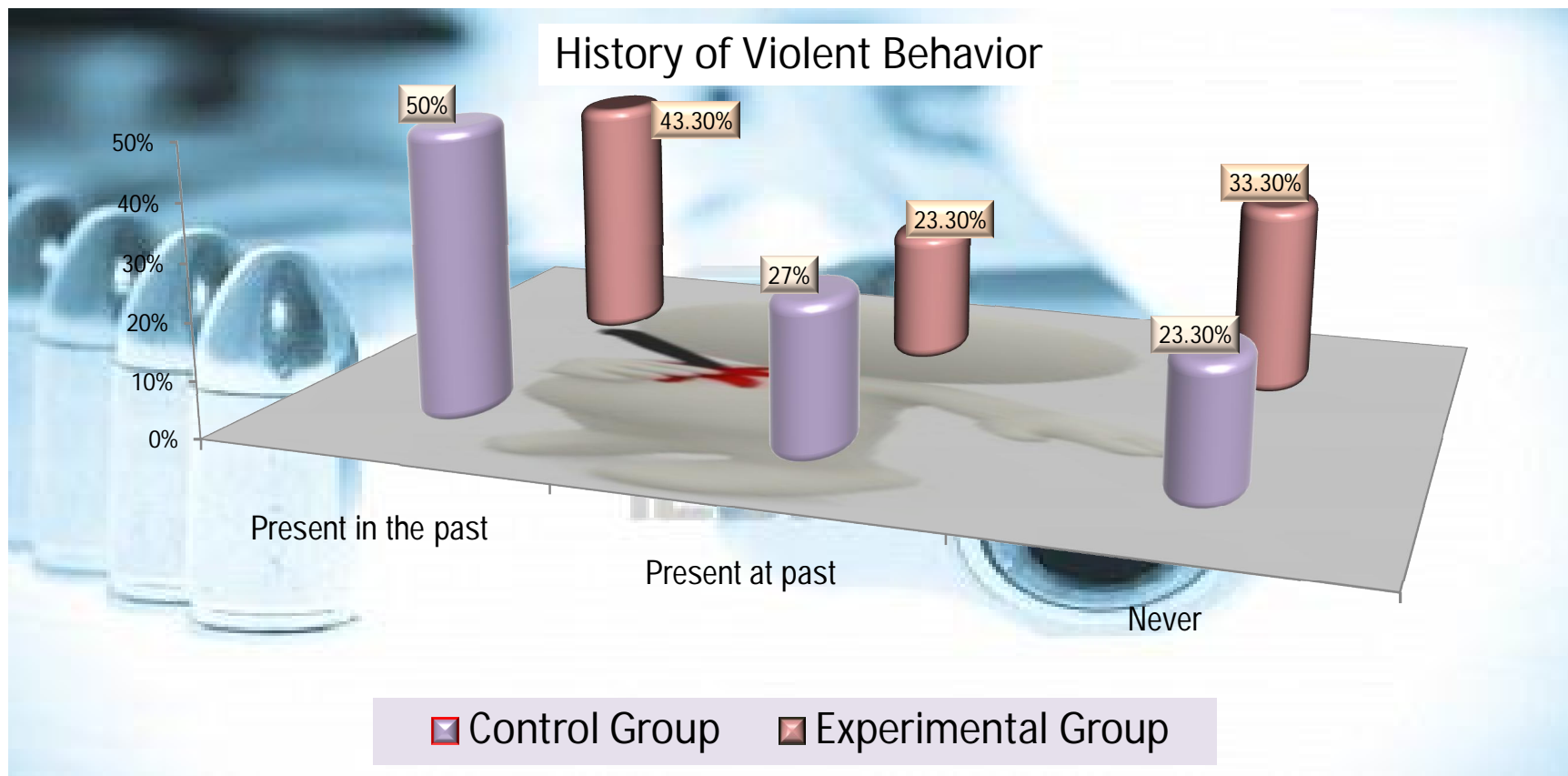


Fig7: Percentage Distribution of History of Violent Behavior in the Control and Experimental Group of Schizophrenic Clients

Table 3

Frequency and Percentage Distribution of Level of Social Skills Before and After Social Skills Training Program in the Control and Experimental Group of Schizophrenic Clients.

Levels of Social Skills	Control Group(n=30)				Experimental Group(n=30)			
	Before Intervention		After Intervention		Before Intervention		After Intervention	
	n	p	n	p	n	p	n	p
Very Low Level of Social Skills	15	50	17	56.66	17	56.66	-	-
Low Level of Social Skills	15	50	13	43.33	13	43.33	5	16.66
Moderate Level of Social Skills	-	-	-	-	-	-	5	16.66
High Level of Social Skills	--	-	--	-	-	-	15	50

It can be inferred from the table 3 that most of the schizophrenic clients before social skills training program (50%, 56.66%) had very low level of social skills in the control and experimental group respectively. Most of the clients in the experimental group after social skills training program (50%) had high levels of social skills. Whereas in the control group most of the clients before and after social skills training program had very low level of social skills (50%, 56.66%).

Table 4

Domain Wise Frequency and Percentage Distribution of Level of Satisfaction Scores Regarding Social Skills Training Program in the Experimental Group of Schizophrenic Clients.

Item	Highly Satisfied		Satisfied		Dissatisfied		Highly Dissatisfied	
	n	p	n	p	n	p	n	P
Over All Satisfaction	30	100	-	-	-	-	-	-
Related to Researcher	30	100	-	-	-	-	-	-
Related to The Social Skills	30	100	-	-	-	-	-	-

It can be inferred from the table 4 that all of the schizophrenic clients (100%) were highly satisfied with all the aspects of social skills training program.

Table 5

Comparison of Mean and Standard Deviation of Social Skills Scores Before and After Social Skills Training Program Between control and experimental group of Schizophrenic Clients.

Social Skills Scores	Before Intervention				After Intervention		
	n	Mean	SD	“t” Value	Mean	SD	“t” Value
Global Social Skills Scores							
Control Group	30	28.2	4.6	0.137	27.8	4.5	13.607***
Experimental Group	30	28.9	4.3		40.7	4	
Patients Self Report							
Control Group	30	12.4	2.8	0.32	12.57	2.5	8***
Experimental Group	30	12.4	2.8		17.13	4.96	
Researchers Observation							
Control Group	30	13.47	3.01	0.833	12.8	2.6	12.31***
Experimental Group	30	14.07	3.12		19.57	2.94	
Others							
Control Group	30	2.43	1.00	0.23	2.27	1.11	7.594***
Experimental Group	30	2.5	1.07		3.87	3.01	

***P < 0.001

The data presented in the table 5 depicted that the scores of social skills before social skills training program of the control and experimental group (M = 28.2, SD = 4.6) and (M = 28.9, SD = 4.3) was not significant. On the other hand the scores of the

control and experimental group after the SSTP ($M=27.8$, $SD = 4.5$) and ($M =40.7$, $SD = 4$) shows that scores of experimental group is high when compared to the scores of control group. The difference found was statically significant at $P < 0.001$ level of confidence which can be attributed to the effectiveness of SSTP.

The mean and standard deviation scores of the control and experimental group based on the domains are also presented in the table 6 it depicted that social skills scores before SSTP of the control and experimental group (patient self report $M= 12.4$, $SD =2.8$, researchers observation $M = 13.47$, $SD = 3.07$ others $M=2.43$, $SD =1.00$) and (patient self report $M= 12.4$, $SD =2.8$, researchers observation $M = 14.07$, $SD = 3.12$ others $M=2.5$, $SD =1.07$) was not significant. On the other hand scores based on the domains after the SSTP of the control (patient self report $M= 12.57$, $SD =2.5$, researchers observation $M = 12.8$, $SD =2.6$, others $M=2.27$, $SD =1.11$) and experimental group (patient self report $M= 17.13$, $SD = 4.96$, researchers observation $M=19.57$, $SD =2.94$, others $M=3.87$, $SD =3.01$) shows that scores of experimental group were high when compared to the scores of control group. The difference found was statistically significant at $P < 0.001$ level of confidence which can be attributed to the effectiveness of SSTP.

Table 6

Association Between the Selected Demographic Variables and the Level of Social Skills Before and After Social Skills Training Program in Control Group of Schizophrenic Clients.

(N=30)

Demographic Variables	Before Intervention			After Intervention		
	Up to mean	Above mean	χ^2	Up to mean	Above mean	χ^2
Age in years						
30-40	5	3		4	3	
41-50	5	3	0.002	2	6	0.2
51-60	7	7	df=1	5	9	df=1
Gender						
Male	10	9	0.51	6	13	0.21
Female	7	4	df=1	4	7	df=1
Educational status						
Non literate	2	3		1	4	
Primary school	3	2		2	3	
Secondary	3	3		1	5	
Higher secondary	5	1	0.63	4	2	3.63
Graduate and above	4	4	df=1	4	4	df=1
Occupation						
Unemployed	4	9		2	11	
Agricultural	1	1		2	-	
Laborer	3	-		3	-	
Technical	3	-		2	1	
Business	4	1		1	4	
Professional	-	1		-	1	
House wife	2	1	0.601	2	1	0.44
Shop keepers	-	-	df=1	-	-	df=1

Monthly family income in rupees						
5000- 10000	9	10		8	11	
10,101-20000	1	3	1.37	1	2	0.193
20,101-30000	2	5	df=1	3	4	df=1
Marital status						
Married	10	7		7	10	
Unmarried	3	3		1	5	
Separated	3	-	0.18	3	-	1.22
Widow/Widower	1	3	df=1	1	3	df=1
Religion						
Hindu	13	9		9	13	
Muslim	1	2	0.33	2	1	1.38
Christian	3	2	df=1	1	4	df=1
Type of family						
Nuclear	11	11	1.74	8	14	0.6
Joint	6	2	df=1	4	4	df=1
Area of residence						
Urban	12	7	0.85	10	9	0.23
Rural	5	6	df=1	2	17	df=1

Note: categories under the variables were clubbed for the sake of chi-square analysis.

It could be inferred from the table 6 that there is no significant association between selected demographic variables and level of social skills ($p > 0.05$). Hence the null hypothesis Ho2 “There will be no significant association between the level of social skills and the selected demographic variables before and after social skills training program in the control and experimental group of schizophrenic clients” was retained.

Table 7

Association Between the Selected Demographic Variables and the Level of Social Skills Before and After Social Skills Training Program in Experimental Group of Schizophrenic Clients.

(N=30)

Demographic Variables	Before Intervention			After Intervention		
	Up to mean	Above mean	χ^2	Up to mean	Above mean	χ^2
Age in years						
30-40	4	5		5	7	
41-50	3	7	1.2	4	2	0.2
51-60	3	8	df=1	9	3	df=1
Gender						
Male	9	10	0.61	7	12	0.22
Female	6	5	df=1	5	6	df=1
Educational status						
Non literate	-	4		1	3	
Primary school	3	-		2	1	
Secondary	4	1		4	1	
Higher secondary	4	4	1.1	2	2	0.5
Graduate and above	5	7	df=1	2	8	df=1
Occupation						
Unemployed	3	4		2	5	
Agricultural	2	2		1	3	
Laborer	1	1		1	1	
Technical	1	3		2	2	
Business	1	1		-	2	
Professional	-	2	1.22	1	1	
House wife	2	-	df=1	2	-	0.37
Shop keepers	5	2		3	4	df=1
Monthly family income in rupees						
5000- 10000	10	7		8	9	
10,101-20000	4	4	0.5	3	5	0.14
20,101-30000	2	3	df=1	4	1	df=1

Marital status						
Married	5	2		3	4	
Unmarried	7	8	0.68	6	9	
Separated	3	3	df=1	3	3	0.22
Widow/Widower	-	2		-	2	df=1
Religion						
Hindu	11	9		8	12	
Muslim	1	4	0.75	3	2	0.157
Christian	3	2	df=1	1	4	df=1
Type of family						
Nuclear	7	6	2.64	6	10	0.095
Joint	7	10	df=1	6	8	df=1
Area of residence						
Urban	10	11	0.32	7	14	0.454
Rural	5	4	df=1	4	5	df=1

Note: Categories under the variables were clubbed for the sake of chi-square analysis.

It could be inferred from the table 7 that there is no significant association between demographic variables and level of social skills ($p > 0.05$). Hence the null hypothesis Ho2 “There will be no significant association between the level of social skills and the selected demographic variables before and after social skills training program in the control and experimental group of schizophrenic clients” was retained.

Table 8

Association Between the Selected Clinical Variables and the Level of Social Skills Before and After Social Skills Training Program in Control Group of Schizophrenic Clients.

(N=30)

Clinical Variables	Before Intervention			After Therapy		
	Up To Mean	Above Mean	χ^2	Up To Mean	Above Mean	χ^2
History of previous hospitalization.						
Yes	14	7	0.7	8	13	0.24
No	3	6	df=1	4	5	df=1
Sources of help sought by clients.						
Traditional Healing	2	1		2	1	
Temple Priests	2	2		-	4	
Churches	2	-		-	2	
Mosques	-	1		-	1	
Black magic	-	2		1	1	
Exorcist	-	1		-	1	
Medical facilities	5	6	0.23	4	7	2.6
Others	6	-	df=1	5	1	df=1
Family history of mental illness						
Present	8	10	2.9	6	12	0.83
Absent	9	3	df=1	6	6	df=1
If present relationship to the client						
First degree	4	7		4	7	
Second degree	3	2	0.97	2	3	2.8
Third degree	1	1	df=1	1	1	df=1

History of violent behavior.						
Yes in the past	9	6	1.1	5	10	
Yes at present	3	5	df=1	3	5	1.7
Never	5	2		4	3	df=1
Interval between illness and treatment						
Immediately	10	6		5	11	
Up to 1 year	-	5		1	4	
>1 year	2	2	3.31	2	2	2.27
Not sure	5	-	df=1	3	2	df=1

Note: Categories under the variables were clubbed for the sake of chi-square analysis.

It could be inferred from the table 8 that there is no significant association between clinical variables and level of social skills ($p > 0.05$). Hence the null hypothesis Ho3 “There will be no significant association between the level of social skills and the selected clinical variables before and after social skills training program in the control and experimental group of schizophrenic clients” was retained.

Table 9

Association Between the Selected Clinical Variables and the Level of Social Skills Before and After Social Skills Training Program in Experimental Group of Schizophrenic Clients.

(N=30)

Clinical Variables	Before Intervention			After Therapy		
	Up To Mean	Above Mean	χ^2	Up To Mean	Above Mean	χ^2
History of previous hospitalization.						
Yes	12	13	0.5	10	15	0.3
No	3	2	df=1	2	3	df=1
Sources of help Sought by clients.						
Traditional Healing	2	1		2	1	
Temple Priests	2	2		3	1	
Churches	1	1		1	1	
Mosques	1	-		-	1	
Black magic	-	2		-	2	
Exorcist	-	1		-	1	
Medical facilities	4	5	0.73	2	7	3.4
Others	5	3	df=1	3	5	df=1
Family history of mental illness						
Present	13	7	0.56	8	12	0.17
Absent	2	8	df=1	4	6	df=1
If present relationship to the client						
First degree	11	5		7	9	
Second degree	1	1	2.31	1	1	0.03
Third degree	1	1	df=1	-	2	df=1

History of violent behavior.						
Yes in the past	5	8		5	8	
Yes at present	4	3	0.75	4	8	0.82
Never	6	4	df=1	3	7	df=1
Interval between illness and treatment						
Immediately	8	6		6	8	
Up to 1 year	2	4		3	3	
>1 year	4	2	0.12	3	3	0.82
Not sure	1	3	df=1	-	4	df=1

Note: Categories under the variables were clubbed for the sake of chi-square analysis.

It could be inferred from the table 9 that there is no significant association between clinical variables and level of social skills ($P > 0.05$). Hence the null hypothesis Ho3 “There will be no significant association between the level of social skills and the selected clinical variables before and after social skills training program in the control and experimental group of schizophrenic clients” was retained.

Summary

This chapter has dealt with the analysis and interpretation of the data obtained by the researcher. The analysis of the results showed that the level of social skills was increased after social skills training program when compared to before the administration. This can be attributed to the effectiveness of social skills training program.

CHAPTER - V

DISCUSSION

Data relevant to the research findings were presented in Chapter IV. Discussion of these results and their implications are presented in two sections: An investigation of the data regarding the research hypotheses is followed by a presentation of the implications for further research.

The quasi experimental study was conducted to determine the effectiveness of SSTP among the schizophrenia clients in Asha Psychiatric Rehabilitation Home for Schizophrenia, Chennai, West Tambaram.

Objectives of the Study

1. To assess the level of social skills in the control and experimental group of the schizophrenic clients before and after social skills training program.
2. To evaluate the effectiveness of social skills training by comparing the level of social skills in control and experimental group of schizophrenic clients before and after Social skills training program.
3. To determine the level of satisfaction regarding social skills training program among experimental group of schizophrenic clients.
4. To find out the association between level of social skills and selected demographic variables in control and experimental group of schizophrenic clients before and after Social skills training program.

5. To find out the association between level of social skills and selected clinical variables in control and experimental group of schizophrenic clients before and after Social skills training program.

A total of 60 schizophrenic clients were chosen to participate in the study from selected schizophrenia centers at Chennai. The level of social skills was assessed before and after social skill training program in the control and experimental group of schizophrenic clients.

The discussion is presented as follows

- The demographic variables of the schizophrenic clients.
- The clinical variables of the schizophrenic clients.
- Levels of social skills in control and experimental group before and after social skills training program among schizophrenic clients.
- Effectiveness of social skills training program on social skills.
- To determine the level of satisfaction regarding social skills training program among experimental group of schizophrenic clients.
- Association between selected demographic variables and level of social skills in the control and experimental group before and after social skills training program among schizophrenic clients.

- Association between selected clinical variables and level of social skills in the control and experimental group before and after social skills training program among schizophrenic clients.

Demographic variables of schizophrenic clients

In this study most of the clients in this study were males (63%, 63%), Hindus (73%, 67%), with the family income between 5000-10,000/month (63.3%, 57%) in the control and experimental group respectively. Significant percentage of the clients belongs to joint family (53%, 47%), aged above 50 years (43%.33%), (20%, 50%) unmarried in the control and experimental group respectively.

It is known fact that Schizophrenia is more common among males and chronic in nature which needs treatment for longer duration. Clients are also getting admitted in the hospital for longer period because of which most of the psychiatric beds are occupied by schizophrenic clients. In this study significant percentage of the clients were unmarried even though their predominant age is between 40 to 50 years. This indicates the reality that schizophrenic clients remain unmarried as they will not be able to fulfill the responsibility of the family.

In this study predominance of clients belongs to Hindu religion (73%, 67%) and from the urban back ground (63%, 70%) which may be due to the factors such as study setting which is situated in the urban area. This may be because urban people are more educated, they may be aware of the treatment facilities for mental illness, thus seeking help from mental health settings were as people from rural area, tend to visit the traditional healers for their treatment. It is consistent to the study conducted in Netherland among 2500 residential areas to assess the schizophrenia rates in the

urban and rural area findings says that 80% of the schizophrenic clients are from the urban area (Deker et al., 1997).

Thus it is important for the nurses to plan for the strategies such as social skills training program, assertiveness training, etc., in order to improve the socialization of the clients which helps to improve their overall quality of life, reduction of relapse and good prognosis.

The clinical variables of schizophrenic clients

In this study most of the study clients sought help from other traditional sources (63.3%, 73.3%) for their treatment, have family history of mental illness (60%, 66.7%) and they are first degree relatives (36.7%, 53.3%) to the clients in control and experimental group respectively. Significant percentage of the clients got treatment immediately after the onset of illness (53.3%, 46.7%) in control and experimental group respectively.

Majority of the study participants have the history of previous hospitalization (70%, 83.3%) which may be due the fact that schizophrenia is a non curable, life term illness and in which the relapse is more commonly seen problem in the psychiatric illness. The present study finding indicates that most of the clients have the history of violent behavior. In fact some patient's symptoms are associated with violence, which is confounded by delusion of persecution. If a person with schizophrenia becomes violent, the violence is usually directed at family members and tends to take place at home (NIMH, 2008).

Thus it is important for the nurses to educate the family members about the nature of illness and dealing measures with the violent behavior while taking care of the clients, as the reactions of the family members like beating , scolding ,locking in the room may aggravate the violent behavior of the clients.

In current study majority of the study participants have the family history of mental illness (60%, 66.7%) and most of the relatives of the participants are first degree relatives (36.7%, 53.3%).It may be due to the fact that mental disorders run through families, the schizophrenia has the strong genetic vulnerability and studies are ongoing to find the definite biological marker, to find the specific genes are important which increases the vulnerability (Townsend, 2009). It is consistent with the study which was conducted to assess the effects of family history on the schizophrenia study findings shows that the respective relative risks of schizophrenia for persons with a mother, father, or sibling who had schizophrenia were 9.31, and 6.99, as compared with persons with no affected parents or siblings. The population risk was 5.5 percent for a history of schizophrenia in a parent or sibling.

Majority of the study clients in this study initially visited traditional practitioners for treatment (63.3%, 73.3%). It is true that majority of the persons in Asian countries usually visit the traditional practitioners as they believe that mental illness is due to witch craft etc. Thus they visit the psychiatric services when the symptom becomes worse or does not respond to the traditional practices. It is consistent to the Paper analysis which was done in the wood bridge hospital among 153 first admissions of the psychiatric clients comprises population of Chinese ,Malays, Indians and others to assess the ratio who have been to the traditional healers

prior to the hospitalization. The study finding shows that 75% of them have been treated with the traditional healers prior to the hospitalization (Tan et al., 1971).

This underscores the magnitude of the problem and need for the nurses to plan for the strategies to create awareness to remove the misconception about the mental illness among general population, patients and the Family members through various strategies such as health education, propaganda through mass media such as news paper ,television , social welfare program etc.

Levels of social skills in the control and experimental group of schizophrenic clients before and after social skills training program

In this study most of the schizophrenic clients before social skills training program (50%, 56.66%) had very low level of social skills in the control and experimental group respectively. Most of the clients in the experimental group after social skills training program (50%) had high levels of social skills. Were as in the control group most of the clients before and after social skills training program (50%, 56.66%) had very low level of social skills.

Effectiveness of Social Skills Training Program on Social Skills

In this study the scores of social skills before social skills training program of the control and experimental group ($M = 28.2$, $SD = 4.6$) and ($M = 28.9$, $SD = 4.3$) were not significant ($p > 0.05$). On the other hand the scores of the control and experimental group after the SSTP ($M=27.8$, $SD = 4.5$) and ($M =40.7$, $SD = 4$) shows that scores of experimental group is high when compared to the scores of control group. The difference found was stastically significant at $P < 0.001$ level of

confidence .The findings indicates that social skills training program improved the level of social skills among the schizophrenic clients

This findings support various other studies which have proved that social skills training program has been effective throughout the life process of the schizophrenic clients

Kopelowicz et al., in 1997 assessed the effectiveness of social skills training for individuals with schizophrenia with and without deficit syndrome. Social skills and negative symptoms were evaluated before and after training and at 6-month follow-up. Patients with schizophrenia who did not have the deficit syndrome demonstrated significantly better social skills and lower negative symptoms both after training and at follow-up than did those who had the deficit syndrome. Schizophrenia patients with nondeficit negative symptoms appear amenable to intensive social skills training, but schizophrenia patients with the deficit syndrome may have significant deficits in skill acquisition.

Tsang et al., 2001 stated that vocational social skills training program developed in Hong Kong for people affected by chronic schizophrenia improved their ability to find and keep a job. A social skills training group with follow-up support, a social skills training group without follow-up support, and a comparison group who received standard after-care treatment. Participants who had participated in either of the training groups statistically outperformed those in the comparison group. Those receiving the training plus follow-up were statistically much more successful at finding and keeping a job than participants in either of the other two groups. A comparatively small amount of follow-up contact (a monthly group meeting or phone

call) for 3 months after the training finished had a very significant effect on participants' success rate.

A study of Social skills training consists of learning activities utilizing behavioral techniques that enable persons with schizophrenia and other disabling mental disorders to acquire interpersonal disease management and independent living skills for improved functioning in their communities. When the type and frequency of training is linked to the phase of the disorder, patients can learn and retain a wide variety of social and independent living skills.

Generalization of the skills for use in everyday life occurs when patients are provided with opportunities, encouragement, and reinforcement for practicing the skills in relevant situations. Recent advances in skills training include special adaptations and applications for improved generalization of training into the community (Geffen, 2006).

The level of satisfaction of schizophrenic clients regarding social skills training program

The level of satisfaction on social skills training program indicated from the analysis that all the schizophrenic clients had high level of satisfaction regarding training program (100%). The study clients requested the nurse researcher to conduct the program daily in their rehabilitation center.

Association between selected demographic variables and the level social skills before and after social skills training program in the control and experimental group of the schizophrenic clients

Chi square test was used to find out the association between selected demographic variables and level of social skills. It was found that there is no significant association between the selected demographic variables and the level of social skills among schizophrenic clients in the experimental group and the control group ($p > 0.05$). From this inference we can understand that schizophrenic clients lack social skills irrespective of their demographic variables. This reflects the need for nurses to focus on all the clients invariably.

Thus it is important for the nurses to conduct training program to promote socialization using various strategies like role play, Group discussion and health education, community participation for the schizophrenic clients to enhance social skills.

Association between selected clinical variables and the level social Skills before and after social skills training program in the control and experimental group of the schizophrenic clients

Chi square test was used to find out the association between selected clinical variables and level of social skills. It was found that there is no significant association between the selected clinical variables and the level of social skills among schizophrenic clients in the experimental group and the control group ($p > 0.05$). From this inference we can understand that schizophrenic clients lack social skills

irrespective of their clinical variables. This reflects the need for nurses to focus on all the clients invariably.

Finally the present study findings had thrown light on the effectiveness of social skills training program in the improvement of level social skills among schizophrenic clients to improve their life skills, as well as the training program could mould their level of social participation , stress management, human relations. Social skills have shown to be positively related to job performance at all levels, especially where the job demands a higher degree of social interaction.

Goleman in his book stated that IQ contributes only 20% of success in life, and the other forces contribute the rest. Taking the words of the Goleman in to consideration the researcher has streamered the social skills training program for creating a successful balanced cognitive and emotional, economical and relapse free life for schizophrenic clients. The other important focused area was to effectively manage and express emotions (Assertiveness, Stress Management), establish and maintain healthy relationships (basic conversation skills and assertiveness), drug management (prevent relapse) lastly group participation. . The result from the present study shows that SSTP will be the part of the management of schizophrenia clients in future.

We are in the modern materialistic era which demands good communication skills and more adaptation for the change of the globe modernization the other aspect of the global modernization leads to stress which is the major cause for all the mental disorders. Person who lacks certain social skills may have great difficulty in building

a network of supportive friends and acquaintances as he or she grows older, and may become socially isolated.

Moreover, one of the consequences of loneliness is an increased risk of developing emotional problems or mental disorders. Social skills training have been shown to be effective in treating clients with a broad range of emotional and psychiatric problems when added with the treatment.

Some of the disorders treated by social skills trainers include shyness; adjustment disorders; marital and family conflicts, anxiety disorders, attention-deficit/hyperactivity disorder , social phobia , alcohol dependence; depression; bipolar disorder ; schizophrenia ; developmental disabilities; avoidant personality disorder , paranoid personality disorder , obsessive-compulsive disorder and schizotypal personality disorder It's also useful for the normal population.

Summary

This chapter has dealt with the objectives of the study, major findings of the demographic and clinical variables of the schizophrenic clients, level of social skills before and after SSTP, association between selected demographic variables, clinical variables and the level of social skills and the level of satisfaction on SSTP.

CHAPTER – VI

SUMMARY, CONCLUSION, IMPLICATIONS AND RECOMMENDATIONS

This is the most resourceful and demanding part of the study. This chapter gives a brief account of the present study including the summary, conclusion drawn from the findings, recommendations for the study and nursing implications.

Summary

Quasi Experimental Study Was Conducted to Assess the Effectiveness of Social Skills Training Program upon Level of Social Skills Among the Schizophrenia Clients of Asha Psychiatric Rehabilitation Center at West Tambaram, Chennai.

Objectives of the Study

1. To assess the level of social skills in the control and experimental group of the schizophrenic clients before and after social skills training program.
2. To evaluate the effectiveness of social skills training by comparing the level of social skills in control and experimental group of schizophrenic clients before and after Social skills training program.
3. To determine the level of satisfaction regarding social skills training program among experimental group of schizophrenic clients.
4. To find out the association between level of social skills and selected demographic variables in control and experimental group of schizophrenic clients before and after Social skills training program.

5. To find out the association between level of social skills and selected clinical variables in control and experimental group of schizophrenic clients before and after Social skills training program.

Null Hypothesis

- Ho₁** There will be no significant difference in the level of social skills of control and experimental group of schizophrenic clients before and after social skills training program.
- Ho₂** There will be no significant association between the level of social skills and the selected demographic variables before and after social skills training program in the control and experimental group of schizophrenic clients.
- Ho₃** There will be no significant association between the level of social skills and the selected clinical variables before and after social skills training program in the control and experimental group of schizophrenic clients.

Major Findings of the Study

Demographic variables of schizophrenic clients

The study findings indicates that most of the clients in this study were males (63%, 63%), Hindus (73%, 67%), with the family income between 5000-10,000/month (63.3%, 57%) in the control and experimental group respectively. Significant percentage of the clients belongs to joint family (53%, 47%), aged above 50 years (43%.33%), (20%, 50%) unmarried in the control and experimental group respectively.

Clinical variables of schizophrenic clients

The study findings indicates that most of the study clients sought help from other traditional sources (63.3%, 73.3%) for their treatment, have family history of mental illness (60%, 66.7%) and they are first degree relatives (36.7%, 53.3%) to the clients in control and experimental group respectively. Significant percentage of the clients got treatment immediately after the onset of illness (53.3%, 46.7%) in control and experimental group respectively.

Mean and standard deviation of social skills scores of schizophrenic clients before and after social skills training program

The mean percentage and standard deviation scores of social skills before social skills training program of the control and experimental group ($M = 28.2$, $SD = 4.6$) and ($M = 28.9$, $SD = 4.3$) were not significant ($p > 0.05$). On the other hand the scores of the control and experimental group after the SSTP ($M=27.8$, $SD = 4.5$) and ($M =40.7$, $SD = 4$) shows that scores of experimental group is high when compared to the scores of control group. The difference found was stastically significant at $P < 0.001$ level of confidence. Hence the study results shows that social skills training program enhance level of social skills of schizophrenic clients.

Level of satisfaction of social skills training program

The percentage distribution of level of satisfaction on social skills training program indicated that all of them (100%) are highly satisfied.

Association between the selected demographic variables and level of social skills of schizophrenic clients

Association between selected demographic variables and the level of social skills was analyzed statistically using Chi square test. It was inferred that there was no significant association between selected demographic variable and the level of social skills. Hence the null hypothesis H02 was retained.

Association between the selected clinical variables and level of social skills of schizophrenic clients

Association between selected clinical variables and the level of social skills was analyzed statistically using Chi square test. It was found that there is no significant association between the selected clinical variables and the level of social skills among schizophrenic clients in the control group and experimental group ($p > 0.05$). Hence the null hypothesis H03 was retained.

Conclusion

The study findings revealed that the social skills training program was effective in improving level of social skills among schizophrenic clients. It provides excellent frame work to understand the level of social skills and how they manage the social activities in the society, also lead the life independently with the economic support. Therefore this finding is an important contribution to the growing body of research in social skills, and schizophrenic clients must be trained on social skills so that they face the challenging society with confidence and take the challenges successfully

placed on them in the life process in order lead the life independently in all aspects including economically by holding the job with confidence.

Implications

The implication for nursing practice, nursing education, nursing administration and nursing research are presented based on the findings.

Nursing practice

Inter personal skills refers to those interpersonal aspects of communication and social skills that people need to use in direct person to person contact (kay et al.,1986).Top of Form

Social skills

Nurses need to have “people skills” – they have to be emotionally healthy, compassionate and honest, and be able to use good judgment where the health and welfare of the patients is concerned. Nurses also have to be able to work well with others, as having a good relationship with co-workers is paramount, and be able to handle stress, make decisions under pressure and adapt to change and uncertainty while caring for patients.

Communication

Nurses must be able to read, write, speak and comprehend to serve as a health care professional; a nurse has to communicate effectively with patients and with the other members of the health care team.

Adaptability

Health care is a constantly changing field, and a nurse must have the ability to change and adapt to the new procedures available in the industry is very important. In fact, it could mean the difference between life and death for the clients. Nursing is an amazing field, and she lives with change as a nurse she should forever become a part of change. If she is excellent in adaptation to the change, manage stress in the field as well in the patient care; she can make an excellent addition to the profession.

Nursing education

Integration of theory and practice is vital need and it is important in nursing education. Even though social skills is very old concept students are unaware of effective practice of the social skills, hence to enhance effective practice of social skills which help in effective client care and success full professional and personal life ,social skills are vital in this trendy and mechanical society. Hence Nursing curriculum should be incorporated with social skills. The nursing students should be taught about the importance of social skills and the training must be provided in direction of obtaining the skills for self, to others. The social skills can be incorporated in the nursing curriculum are

- Techniques to manage stress.
- Techniques of problem solving.
- Communication techniques.
- Maintain human relations.
- Develop new styles and healthy coping skills.
- Relaxation techniques (e.g.: Breathing exercise, sleeping, etc...)

Nursing administration

Administrators should periodically organize formal training program for nurses to know about social skills which can be practiced in main stream of the life process. She can arrange for conference, in service education, workshop which might be useful to the staffs. As well as the students to teach and practice social skills. Organizing the training program with experts as a resource person will develop interest which will be a right way of imparting knowledge to the participants, by which the social skills can be enhanced and practiced throughout the life.

Nursing research

There is a need for extensive research in this area. It opens a big avenue for research as quality and cost effectiveness so as to generate more scientific data based on critical analysis. Disseminate the findings via conferences, seminars, publications, in professional, national, international, journals and the world wide website. More research needs to be conducted focusing on academic performance with the use of locally available resources. Meta analysis studies to be conducted to finalize the training modalities which will serve all the population by introducing effective strategies.

Nursing theory

The conceptual model exclusively for the use of improving the level of social skills is yet to be developed by nursing theorist. The path analysis used to identify the determinant of social skills among schizophrenic clients was prevented in the present

study in the form of conceptual model which can be used as treatment guide for schizophrenic clients

Recommendations

- Study can be to assess the Effectiveness of different methods and models on social skills.
- Study can be conducted on larger sample to generalize the findings.
- Similar studies can be conducted in different settings like other psychiatric disorders, and also on different age group.
- Longitudinal study can be conducted to assess the long term effects of SSTP.

Limitations

- The study findings cannot be generalized due to small sample size.
- Random sampling was not possible due to practical difficulties.
- True experimental study could not be conducted due to practical difficulties and threat of contamination effects.

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APPENDIX I

LETTER SEEKING PERMISSION TO CONDUCT THE STUDY

CO/0143/11		Apollo College of Nursing
<i>(Recognised by the Indian Nursing Council and Affiliated to the Tamil Nadu Dr. M.G.R. Medical University, Chennai)</i>		
15/03/2011		

To

The Medical Director,
Asha Psychiatric Hospital,
Tambaram
Chennai.

Respected Sir / Madam,


Sub.: To request permission for research study – Reg.

Greetings! As part of the curriculum requirement our 1st year M. Sc. (N) student Ms. Sathya Narayani has selected the following title for her research study.

“An experimental study to Assess the Effectiveness of social skills Training on Social skill among schizophrenia clients in Selected mental hospitals Chennai.”


So I kindly request your goodselves to permit her to conduct study in your esteemed institution.

Thanking You,


Dr. LATHA VENKATESAN
PRINCIPAL

IS/ISO 9001:2000

Vanagaram to Ambattur Main Road, Ayanambakkam, Chennai - 600 095.
Ph. : 044 - 2653 4387 Tele fax : 044 - 2653 4923 / 044- 2653 4386



APPENDIX II

LETTER PERMITTING TO CONDUCT STUDY

ASHA PSYCHIATRIC HOME FOR SCHIZOPHERNIA

West Tambaram, Chennai-600 045,

Phone; 044-64537354.

Date: 13.6.2011,

Chennai.

To

The Principal,

Apollo College Of Nursing,

Vanagaram –Ambatur Main Road,

Ayanambakkam,

Chennai- 600 095.

Dear Madam,

SUB: granting permission to conduct experimental research study with our residents-reg.

With reference to your letter, we are happy to inform you that Ms.Sathya Narayani.S msc (N), II year is permitted to conduct her project work on “A quasi –experimental study to assess the effectiveness of social skills training g on the levels of social skills among schizophrenic clients at selected mental health hospitals Chennai” from 20.6.2011 to 31.6.2011.

Yours sincerely,
Aasha
74, Erikur, S. P. Nagar,
Tambaram East,
CHENNAI - 600 059.
Staff nurse / social worker
M. Sudha

APPENDIX III

ETHICAL COMMITTEE PERMISSION TO CONDUCT THE STUDY

Ethics Committee



22 June, 2011

To
Ms. S. Sathya Narayani
1st Year M.Sc (Nursing)
Dept. of Psychiatry
Apollo College of Nursing, Chennai
Tamil Nadu, India

Ref: Quasi experimental study to assess the effectiveness of social skills training on social skills among schizophrenic clients at selected mental hospitals in Chennai

Sub: Your letter dated 9 June, 2011 for approval of the above referenced project and its related documents

Dear Ms. S. Sathya Narayani,

Ethics committee – Apollo Hospitals has received the following document submitted by you related to the conduct of the above – referenced study.

- Project “Quasi experimental study to assess the effectiveness of social skills training on social skills among schizophrenic clients at selected mental hospitals in Chennai”
- Study Performa
- Informed consent form

The above-mentioned documents have been reviewed and approved (through expedited review) by the Chairman, Vice-Chairman and Member Secretary at a specially convened meeting of the Ethics Committee. The study is hereby approved to be conducted by you in the presented form

The following Ethics Committee members were present at the meeting held on 22 June, 2011

Name	Profession	Position in the committee
Mr. S. S. Narayanan	Ethicist	Chairman
Dr.Radha Rajagopalan	Clinician	Vice - Chairman
Dr. Jayanthi Swaminathan	Sr.GM Clinical & Collaborative Research	Member Secretary

Apollo Hospitals Enterprise Limited
21, Greams Lane, Off Greams Road, Chennai - 600 006
Tel : 91 - 44 - 2829 3333 Extn : 6008, 91 - 44 - 2829 5465 Extn : 6639 Fax : 91 - 44 - 2829 4449
E - Mail : ecapollochennai@gmail.com

Ethics Committee



After due ethical and scientific consideration, the Ethics Committee has approved the above presentation submitted by you.

The Ethics Committee is constituted and works as per ICH-GCP, ICMR and revised Schedule Y guidelines.

Yours sincerely,

Dr. Radha Rajagopalan
Ethics Committee – Vice Chairman
Apollo Hospitals, Chennai

Date 22/6/11

DR. RADHA RAJAGOPALAN
Vice Chairman
Ethics Committee
Apollo Hospitals Enterprise Limited
Chennai 600 006 Tamil Nadu.

Apollo Hospitals Enterprise Limited
21, Greams Lane, Off Greams Road, Chennai - 600 006
Tel : 91 - 44 - 2829 3333 Extn : 6008, 91 - 44 - 2829 5465 Extn : 6639 Fax : 91 - 44 - 2829 4449
E - Mail : ecapollochennai@gmail.com

APPENDIX IV

PLAGIARISM ORIGINALITY REPORT



Plagiarism Detector - Originality Report

Plagiarism Detector Project: [<http://plagiarism-detector.com>] Application core version: 557

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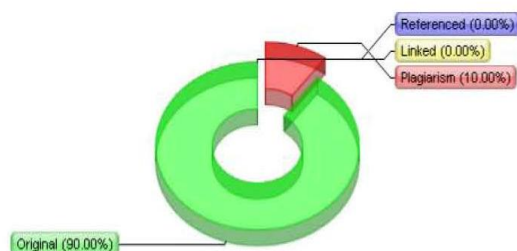
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Originality report details:

Generation Time and Date:	1/20/2012 11:24:11 PM
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APPENDIX V

LETTER REQUESTING OPINIONS AND SUGGESTIONS OF EXPERTS FOR ESTABLISHING CONTENT VALIDITY OF RESEARCH TOOL

From

_____,
M.Sc., (Nursing) Second Year,
Apollo College of Nursing,
Chennai - 600095.

To

Forwarded Through:

Dr. Latha Venkatesan,
Principal,
Apollo College of Nursing,
Chennai- 600095.

Respected Madam/Sir,

Sub: Requesting for opinions and suggestions of experts for establishing content validity for Research tool.

I am a postgraduate student of the Apollo College of Nursing. I have selected the below mentioned topic for research project to be submitted to The Tamil Nadu Dr. M.G.R Medical University, Chennai as a partial fulfillment of Masters of Nursing Degree.

Title of the Topic:

“A Quasi Experimental Study to Assess the Effectiveness of Social Skills Training Program Upon Level of Social Skills Among schizophrenic clients in Selected Mental Hospitals, Chennai.”

With regards may I kindly request you to validate my tool for its appropriateness and relevancy. I am enclosing the Background, Need for the study, Statement of the problem, Objectives of the study, Demographic Variable Proforma, NIMHANS-social skill questionnaire and Rating Scale on Level of Satisfaction of schizophrenic clients regarding social skills training program. I would be highly obliged and remain thankful for your great help if you could validate and send it as soon as possible.

Thanking you,

Yours Sincerely,

APPENDIX VI
CERTIFICATE FOR CONTENT VALIDITY
TO WHOM EVER IT MAY CONCERN

This is to certify that tools and content for the research study developed by _____, II year M.Sc (Nursing) student of Apollo College of Nursing for her dissertation “**A Quasi Experimental Study to Assess the Effectiveness of Social Skills Training Program Upon Level of Social Skills Among schizophrenic clients in Selected mental Hospitals, Chennai**” was validated for content validity.

Signature of the Expert

APPENDIX VII

LIST OF EXPERTS FOR CONTENT VALIDITY

- 1. Dr.Latha Venkatesan, M.Sc.,M.Phil.,Ph.D.,**
Principal and Professor in Maternity Nursing,
Apollo College of Nursing,
Chennai-95
- 2. Dr. MuthuKrishnan, MD., DPM., ABP Psych.,**
Consultant Psychiatrist,
Apollo Main Hospitals,
Chennai-600 006.
- 3. Dr. Peter Fernandez, MD., DPM., TDD., FCCP., FIPS.,**
Consultant Psychiatrist,
DFHS, Porur,
Chennai
- 4. Prof.Lizy Sonia, M.Sc (N).,**
Vice Principal,
Apollo College of Nursing,
Chennai-95.
- 5. Mrs. Jaslina, M.sc (N).,**
Professor,
Apollo College of Nursing,
Chennai-95
- 6. Ms. C. Anuradha, M.sc., (Psychology) M.Sc. (N),**
Reader,
Department of Psychiatric Nursing,
Apollo College of Nursing,
Chennai - 95.
- 7. Ms.Stella Mary. I, M.Sc (N).,**
Lecturer,
Department of Psychiatric Nursing,
Apollo College of Nursing,
Chennai - 95.

APPENDIX VIII
RESEARCH PARTICIPANT CONSENT FORM

Dear Participant,

I am M.Sc., Nursing student of Apollo College of Nursing, Chennai. As a part of my study, I have selected a Research Project on **“A Quasi Experimental Study to Assess the Effectiveness of Social Skills Training Program upon Levels of Social Skills among Schizophrenic Clients in Selected Mental Hospitals, Chennai”**

I hereby seek your consent and co-operation to participate in the study. Please be frank and honest in your response. The information collected will be kept confidential and anonymity will be maintained.

Signature of the Researcher

I,, hereby give my consent to participate in the study.

Signature of the Participant

APPENDIX VIII

$B_{\mu\sigma}{}^{\prime}a]{}^{\circ}\hat{A}\in[S\ddot{e}\ddot{O}\hat{A},UP\grave{o}\acute{U}J^{\prime\prime}|u\hat{A}\hat{e}i\hat{A}^{\circ}$

$A\beta\hat{e}\hat{o}^{\circ}\zeta u\in[S\ddot{e}\ddot{O}\div\hat{A}\hat{o}\div\mu,$

$\{\hat{o}\beta A^{\prime\prime}\div\hat{e}\hat{o}\div\rangle\hat{o}\ddot{o}\backslash\hat{A}\frac{1}{4}{}^{\circ}P\hat{A}\zeta\mathfrak{H}^{\circ}\hat{A}\neg xP\varnothing\rangle\hat{e}^{\circ}\varnothing]\ddot{e}\ddot{e}\ddot{O}^{\circ}$
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APPENDIX IX

CERTIFICATE FOR SOCIAL SKILLS TRAINING PROGRAM



APPENDIX X

CERTIFICATE FOR ENGLISH EDITING

TO WHOMSOEVER IT MAY CONCERN

This is to certify that the dissertation, "A Quasi Experimental Study to Assess the Effectiveness of Social Skills Training Programme Upon Social Skills Among Schizophrenic Clients in Selected Mental Hospitals , Chennai" by Ms. Sathya Narayani.S, II year M.Sc (N) Student, Apollo College of Nursing, was edited for English Language appropriateness.



29/01/12
A. SUUNDARARAJAN, M.A., B.Sc., M.Ed.
P. G. Assistant in ENGLISH,
N. Krishnasamy Mudaliar Hr. Sec. School,
Sainathapuram VELLORE - 638 001
Signature

APPENDIX XI
CERTIFICATE FOR TAMIL EDITING

CERTIFICATE FOR TAMIL EDITING

TO WHOMSOEVER IT MAY CONCERN

This is to certify that the dissertation, “A Quasi Experimental Study to Assess the Effectiveness of Social Skills Training Programme Upon Social Skills Among Schizophrenic Clients in Selected Mental Hospitals , Chennai” by Ms. Sathya Narayani.S, II year M.Sc (N) Student, Apollo College of Nursing, was edited for Tamil Language appropriateness.

Thank you,

Yours sincerely,



Dr. M. MURTHI
Asst. Professor & Head
Department of Tamil
Guru Nanak College,
Chennai-600 042.

APPENDIX- XII

DEMOGRAPHIC VARIABLE PROFOMA OF SCHIZOPHRENIC CLIENTS

Purpose

This scale is developed to assess the baseline details of the clients

Instruction

Please read the questions. Select a correct answers .please describe your responses freely and frankly. The details will be kept confidential and used for research purpose only.

1. Age in Years

1.1 30-40 ☐

1.2 41-50 ☐

1.3 51-60 ☐

2. Gender

2.1 Male ☐

2.2 Female ☐

3. Educational Status

3.1 Non- literate ☐

3.2 Primary school ☐

3.3 Secondary ☐

3.4 higher secondary ☐

3.5 graduate and above ☐

4. Occupation ☐

4 .1 Unemployed ☐

4.2 Former ☐

4.3 Laborer ☐

4.4 Technical	<input type="checkbox"/>
4.5 Business	<input type="checkbox"/>
4.6 Professional	<input type="checkbox"/>
4.7 House Wife	<input type="checkbox"/>
4.8 Any Other	<input type="checkbox"/>
5. Monthly Family Income	
5.15000-10000	<input type="checkbox"/>
5.2 10,001-20,000	<input type="checkbox"/>
5.320.001-30000	<input type="checkbox"/>
6. Marital Status	
6.1 Married	<input type="checkbox"/>
6.2 Unmarried.	<input type="checkbox"/>
6.3 separated	<input type="checkbox"/>
6.4 Widow/widower	<input type="checkbox"/>
7. Religion	
7.1 Hindu	<input type="checkbox"/>
7.2 Muslim	<input type="checkbox"/>
7.3 Christian	<input type="checkbox"/>
7.4 Any others {specify}	<input type="checkbox"/>
8. Type of family	
8.1 Nuclear	<input type="checkbox"/>
8.2 Joint	<input type="checkbox"/>
9. Area of residence	
9.1 Urban	<input type="checkbox"/>
9.2 Rural	<input type="checkbox"/>

APPENDIX- XII

இணைப்பு 1

மாறுபட்டக் குறிப்புகளை அறியும் மாதிரிப்படிவம்

நோக்கம்:

இந்த அளவுகோல் மாறுபட்டக் குறிப்புகளை அறியும் அளவை மதிப்பிடுகிறது.

அறிவுரைகள்:

கேள்விகளைத் தயவுக்கூர்ந்துப் படிக்கவும். உங்களின் பதில்களை வெளிப்படையாகவும் சுதந்திரமாகவும் அளிக்கவும். பதில்கள் இரகசியமாக வைக்கப்பட்டு ஆய்விற்கு மட்டும் பயன்படுத்தப்படும்.

1. மாதிரி எண்
2. வயது (ஆண்டுகளில்)
3. பால்
 - 3.1 ஆண்
 - 3.2 பெண்
4. கல்வித் தகுதி
 - 4.1 படிப்பறிவில்லாதவர்
 - 4.2 ஆரம்பக் கல்வி
 - 4.3 உயர்நிலைக் கல்வி
 - 4.4 மேல்நிலைக் கல்வி
 - 4.5 பட்டப் படிப்பு மற்றும் அதற்கும்மேல்
5. தொழில்
 - 5.1 வேலையற்றவர்
 - 5.2 விவசாயி

- 5.3 கூலி
- 5.4 தொழில் நுட்பம் சார்ந்த
- 5.5 வியாபாரம்
- 5.6 திறத்தொழிலர்
- 5.7 வீட்டு நிர்வாகி
- 5.8 வேறு ஏதேனும்
- 6. மாத குடும்ப வருமானம்
- 7. திருமண நிலை
 - 7.1 திருமணமானவர்
 - 7.2 திருமணமாகாதவர்
 - 7.3 பிரிந்து வாழ்பவர்
 - 7.4 கணவனை/மனைவியை இழந்தவர்
- 8. மதம்
 - 8.1 இந்து
 - 8.2 இஸ்லாமியர்
 - 8.3 கிறித்துவர்
 - 8.4 வேறு மதத்தினர் (குறிப்பிடவும்)
- 9. குடும்ப வகை
 - 9.1 தனிக்குடும்பம்
 - 9.2 கூட்டுக் குடும்பம்
- 10. வசிக்கும் இடம்
 - 10.1 நகரம்
 - 10.2 நகரியம்

APPENDIX XIII

CLINICAL VARIABLE PROFORMA OF SCHIZOPHRENIC CLIENTS

Purpose

This scale is developed to assess the clinical details of the clients

Instruction

Please read the questions. Select a correct answers .please describe your responses freely and frankly. The details will be kept confidential and used for research purpose only.

1. History of Previous Hospitalization.

- | | |
|---------|--------------------------|
| 1.1 Yes | <input type="checkbox"/> |
| 1.2 No | <input type="checkbox"/> |

2. Sources of Help First Sought By Clients

- | | |
|-------------------------|--------------------------|
| 2.1 Traditional Healing | <input type="checkbox"/> |
| 2.2 Temple Priests | <input type="checkbox"/> |
| 2.3 Churches | <input type="checkbox"/> |
| 2.4 Mosques | <input type="checkbox"/> |
| 2.5 Black magic | <input type="checkbox"/> |
| 2.6 Exorcist | <input type="checkbox"/> |
| 2.7 Any others specify | <input type="checkbox"/> |
| 2.8 Medical facilities | <input type="checkbox"/> |

3. Family History of Mental Illness

3.1 Present ☐

3.2 Absent ☐

4. If Present Relationship to the Client

4.1 First degree ☐

4.2 Second degree ☐

4.3 Third degree ☐

5. History of Violent Behavior

5.1 Present in the past ☐

5.2 Present at present ☐

5.3 Never ☐

6. Interval between Illness and Treatment

6.1 Immediately ☐

6.2 Up to 1 year ☐

6.3 >1 year ☐

6.4 Don't know ☐

APPENDIX XIII

இணைப்பு 2.

சிகிச்சைக் குறித்த மாறுபட்டக் குறிப்புகளை அறியும்
மாதிரிப்படிவம்

நோக்கம்:

இந்த அளவுகோல் சிகிச்சைக் குறித்த மாறுபட்டக் குறிப்புகளை
அறியும் அளவை மதிப்பிடுகிறது.

அறிவுரைகள்:

கேள்விகளைத் தயவுக்கூர்ந்துப் படிக்கவும். உங்களின்
பதில்களை வெளிப்படையாகவும் சுதந்திரமாகவும் அளிக்கவும்.
பதில்கள் இரகசியமாக வைக்கப்பட்டு ஆய்விற்கு மட்டும்
பயன்படுத்தப்படும்.

1. மருத்துவமனையில் தங்கி சிகிச்சைப் பெற்ற வரலாறு

அ. உண்டு

ஆ. இல்லை

2. நோயாளிகள் அணுகிய சிகிச்சை முறைகள்

அ. நாட்டு வைத்தியம்

ஆ. கோவில் பூசாரிகள்

இ. கிறித்துவ ஆலயங்கள்

ஈ. மதுதிகள்

உ. மந்திரம்

ஊ. பேய் ஓட்டுதல்

எ. வேறு ஏதேனும் (குறிப்பிடவும்)

ஏ. ஆங்கில மருந்து வசதி

3. குடும்ப மனநிலை நோய்க்கான வரலாறு

அ. உண்டு

ஆ. இல்லை

4. உண்டு எனில் நிலைப்பாடு

அ. முதல் நிலை

ஆ. இரண்டாம் நிலை

இ. மூன்றாம் நிலை

5. முர்க்கமான நடத்தை வரலாறு

- அ. ஆம் ((முந்தையக் காலத்தில்)
- ஆ. ஆம் (இப்பொழுது)
- இ. எப்பொழுதுமில்லை

6. நோய்க்கும் சிகிச்சைக்கும் உள்ள இடைவெளி

- அ. உடனடியாக
- ஆ. ஓர் ஆண்டுவரை
- இ. ஓர் ஆண்டுக்கும்மேல்
- ஈ. தெரியவில்லை

BLUE PRINT FOR SOCIAL SKILLS QUESTIONNAIRE

S.no	Social Skills Assessment	Questions	No. Of Items	Percentage
1.	Self- Report	1-5	5	42%
2.	Observation	6-11	6	50%
3.	Others	12	1	8%
			12	100%

APPENDIX XIV

SOCIAL SKILLS QUESTIONNAIRE

Purpose

The scale assesses the level of social skills of the clients with mental illness.

Instructions

Please read the questions. Please describe your responses freely and frankly. The details will be kept confidential and used only for research purpose

	Mode of Assessment	Rating			
A]	Patients Self Report	Always (4)	Often (3)	Rarely (2)	Never (1)
1.	Are you able to initiate conversation with friends or a group?				
2.	Are you able to maintain conversations initiated by others?				
3.	Are you able to understand feelings of others by looking them?				
4.	Are you comfortable in the group or social gathering?				
5.	Are you able to negotiate with others if you disagree with them in an issue				
B.	Clinicians Observation during the Interview	High [4]	Medium [3]	Low [2]	Nil [1]
6.	Gaze [eye contact]				
7.	Appropriateness of affect				
8.	Non verbal [gestures, interpersonal distance]				
9.	Verbal [the content of the speech]				
10.	Paralinguistic [intonation, pitch, loudness, fluency, turn taking]				
11.	Engagement [the extent to which individual is involved in conversation]				
C	Other information	High [4]	Medium [3]	Low [2]	Nil [1]
12	Patients motivation to change				

Scoring is interpreted as follows:

S.no	Scores	Percentage	Interpretation
1.	<12	<25%	Very low level of social skills
2.	12-24	26 – 50%	Low level of social skills
3.	25-35	51- 75%	Moderate level of social skills.
4.	>35	>75%	High level of social skills

Higher the score better the social skills.

மதிப்பெண் வழிக்காட்டி

மதிப்பெண்	கணிப்பு
மிகவும் திருப்தி	76 - 100%
திருப்தி	51 - 75%
திருப்தியின்மை	25 - 50%
மிகவும் திருப்தியின்மை	25% க்கும் கீழே

APPENDIX XIV

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			(2)	(1)

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8. வார்த்தைகளற்ற (பாவனை,
தன்னகத்து இடைவெளி)

9. வார்த்தை (பேச்சின் சாரம்)

10. உச்சரிப்பு (ஏற்ற இறக்கம்,
அழுத்தம், ஓசை, சரளம்,
எடுத்துக்கொள்ளும் சுற்று)

11. ஈடுப்படுதல் (உரையாடலில்
தனி நபரின் கலந்துக் கொள்ளு
தலின் எல்லை)

இ மற்றத் தகவல்கள்

12. நோயாளிகளின் மாறுதலுக்கான
ஊக்கம்

BLUE PRINT FOR THE LEVEL OF SATISFACTION SCALE

S. no	Criterion	Question	Percentage
1.	Question related to the researcher	1,2,3	30 %
2.	Question related to the social skill	4, 5, 6, 7, 8, 9, 10.	70%

APPENDIX –XV

RATING SCALE FOR THE LEVEL OF SATISFACTION

Rating scale to assess the level of satisfaction regarding social skill training program

Purpose:

This rating scale is destined to assess the level of satisfaction of the participants.

Instructions;

There are 10 items below. Kindly read the items .responses extends from highly Dissatisfied. Put a tick against your answer. Describe your response freely and frankly. The response was be kept confidential and used for research purpose only.

S.no	Item	Highly Satisfied	Satisfied	Dissatisfied	Highly Dissatisfied
1.	Explanation regarding the social skill training program				
2.	Approach of the researcher				
3.	Time spend by the researcher				
4.	Duration of the program				
5.	Arrangement during the program				
6.	Program was easy to understand				
7.	Use of Audio visual aids				
8.	Involvement of participation				
9.	Given at the appropriate time				
10.	Usefulness				

Scoring Key:

Scoring	Interpretation
Highly Satisfied	76 – 100%
Satisfied	51 – 75%
Dissatisfied	25 - 50%
Highly Dissatisfied	Below 25 %

APPENDIX XV

இணைப்பு 4

திருப்தி நிலைக்கான அளவுகோல்

இந்த அளவுகோல் சமூகத் திறன் பயிற்சிப் பற்றிய நிலையை அளக்கிறது

நோக்கம்

இந்த அளவுகோல் பங்குப் பெறுவோரின் சமூகத் திறன் பயிற்சிப் பற்றிய நிலையை நிர்ணயிக்கிறது.

அறிவுரைகள்

கீழே பத்து வகைகள் உள்ளன. தயவுக் கூர்ந்து அவற்றைப் படிக்கவும். பதில்கள் மிகவும் திருப்தியிலிந்து மிகவும் திருப்தியின்மைவரை உள்ளன. உங்களின் பதில்களுக்கு நேராக ✓ செய்யவும். பதில்கள் இரகசியமாக வைக்கப்பட்டு ஆய்விற்ரு மட்டும் பயன்படுத்தப்படும்.

வரிசை எண்	வகை	மிகவும் திருப்தி	திருப்தி	திருப்தி யின்மை	மிகவும் திருப்தி
1.	சமூகத் திறன் பயிற்சிப் பற்றிய விளக்கம்				
2.	ஆய்வாளரின் அனுகுமுறை				
3.	ஆய்வாளர் பயன்படுத்தியக் கால அளவு				
4.	நிகழ்ச்சியின் கால அளவு				
5.	நிகழ்ச்சி ஏற்பாடு				
6.	நிகழ்ச்சியை எளிதாகப் புரிந்துக் கொள்ள முடிந்தது				
7.	ஒளி ஒலி உபகரணங்களின் பயன்பாடு				
8.	பங்குப் பெறுவதில் ஈடுப்பாடு				
9.	சரியான நேரத்தில் கொடுக்கப் பட்டது.				
10..	பயன்பாடு				

APPENDIX –XVI

Item Wise Frequency and Percentage Distribution of Level of Satisfaction Scores of SSTP in the Experimental Group of Schizophrenic Clients

(N=30)

Item	Highly Satisfied		Satisfied		Dissatisfied		Highly Dissatisfied	
	n	p	n	p	n	p	n	p
Explanation regarding								
Social skills training program	26	86.67	4	13.33	-	-	-	-
Approach of the researcher	27	90	3	10	-	-	-	-
Time spend by the researcher	29	96.67	1	3.33	-	-	-	-
Duration of the program	27	90	3	10	-	-	-	-
Arrangements made during the program	26	86.67	4	13.33	-	-	-	-
The program was easy to understand	28	93.33	2	6.66	-	-	-	-
Use of audio visual aids	27	90	3	10	-	-	-	-
Involvement of the								
Participants	27	90	3	10	-	-	-	-
Given at the appropriate time	28	93.33	2	6.66	-	-	-	-
Usefulness	30	100	-	-	-	-	-	-

All the schizophrenic clients (100%) were highly satisfied with all the aspects of social skills training program.

APPENDIX –XVII

SOCIAL SKILLS TRAINING PROGRAM SCHEDULE

Week 1: Over view of social skills domains which are included in the study.

Day one: Introduction to the interpersonal domain like basic conversation, assertiveness, problem solving.

Day two: Introduction to the domain of coping with illness like medication management,

Relapse prevention, stress management, relaxation technique,

Day three: Individual interaction between the researcher and the study participants was made to know the techniques used like role play, video play, teaching strategy, group discussion.

Session 1: Interpersonal domain.

Second week: Basic conversation.

Day one: Communication skills.

Day two: Group discussion arranged to practice communication among the participants.

Day three: Encountered the problems of the clients in the communication and the doubts are clarified.

Day four: Techniques of communication were taught to the participants.

Day five: Group discussion and role play was conducted to enhance the communication techniques.

Third week: Assertiveness

Day one: Techniques of assertiveness.

Day two: Role plays to enhance assertiveness.

Day three: Problem solving techniques.

Day four: Situation was given to the group to assess the effective utilization of the problem solving techniques.

Day five: The researcher asked the individual clients problem and encouraged them to generate various self solution for them by the participants to practice and solve the obstacles in problem solving process (worksheet).

Session 2: Coping with illness.

Fourth week: Medication management.

Day one: Explained about the benefits of drug.

Day two: Taught about the side effects of medication.

Day three: Explained about the drug compliance.

Day four: Self administration of medication.

Day five: Diet that enhance drug effects and diet must be avoided during the treatment

Fifth week: Relaxation Technique.

Day one: Assessed the relaxation techniques used by the clients.

Day two: Breathing exercise.

Day three: Listening to music.

Day four: Session arranged for relaxation.

Day five: Physical exercise.

Sixth week: Relapse prevention.

Day one: Importance of medication and management of relapse.

Day two: Stress management.

Day three: Importance of lifelong medication and doctor consultation.

Day four: Identifying warning symptoms and management.

Day five: Avoid street drugs.

APPENDIX - XVIII

LESSON PLAN ON SOCIAL SKILLS TRAINING

Content For Teaching

TOPIC	-	Social Skills Training.
Group	-	Schizophrenic clients.
Place	-	Asha Psychiatric Rehabilitation for Schizophrenic Clients.
Duration	-	6 weeks Program
Methods of teaching	-	lecture cum discussion, role plays, group discussion, video shows.
Teaching aids	-	power point sessions, video shows Black board.
Educator	-	II year M.sc., (N), Apollo College of Nursing, Chennai.


General objective

The schizophrenic clients will gain adequate knowledge on various aspects of social skills training program like communication assertiveness, problem solving, medication management, stress management, relaxation techniques.

Specific objective

By the end of the program , the schizophrenic clients will be able to

- explain the basic conversation methods.
- choose right ways to deal with conflict.
- utilize the act of assertiveness.
- practice problem identification and problem solving.
- specify strategies to solve problem.
- explain about the side effects and managements.
- prepare clients for relaxation by using relaxation techniques.
- truth about stress and its management.

Time	Specific objectives	Content	Teacher and learner activity	A.V. Aids	Evaluation
10min 20 min	The schizophrenic Clients will be able to, explain basic conversation methods	<p>Social skills training for schizophrenic clients</p> <p>Introduction</p> <p>SST uses the principle of behavior therapy to teach communication skills, assertiveness skills, and other skills related to diseases management and independent living.</p> <p>Basic Conversation</p> <p>Everyone uses interpersonal communication skills. We use them at home with our families, in the workplace with our bosses and coworkers, on our computers when we answer email, and on the telephone when we order pizza. This session will help you persons to improve your interpersonal communication skills and develop new skills to become a more effective communicator.</p>  <p>Interpersonal communication applies to all of our relationships, personal and business. Others respect or reject us based on our interpersonal communication skills.</p>	<p>Introducing the topic and participating in discussion.</p> <p>Listening, Lecture cum Discussion.</p>	Video show	<p>What is the topic we are going to discuss today?</p> <p>Why do we Need the skills To communicate?</p>

		<p>Communication</p> <p>Communication is the ability to use language (receptive) and express (expressive) information.</p> <p>Communication Goals</p> <ul style="list-style-type: none"> ➤ To change behaviors. ➤ To get action. ➤ To ensure understanding. ➤ To persuade. ➤ To get and give information. <p>Common Ways Of Communication</p> <ul style="list-style-type: none"> • Speaking. • Writing. • Visual image. • Body language. <p>Sending Messages</p> <ul style="list-style-type: none"> ➤ Effective verbal message. ➤ Non verbal message. ➤ Para verbal messages. 			
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		<p>Effective Verbal Message</p> <ol style="list-style-type: none"> 1. Must be brief, succinct and organized. 2. Must be free from jargon. 3. Do not create resistance to the learner. <p>Non Verbal Message</p> <p>These are the primary way to communicate emotions.</p> <p>E.g. facial expression.</p> <p>Para Verbal Message</p> <p>Para verbal communication refers to the messages that we transmit through the tone, pitch and pacing of our voices.</p> <p>E.g. “I did not say you were stupid”</p> <p>“I did not say you are stupid”</p> <p>“I did not say you are stupid”</p> <p>Receiving Message</p> <p>Listening</p> <p>Includes a desire and willingness to try and see things from another’s perspective.</p>			
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		<p>Key Listening Skills</p> <p>Nonverbal</p> <ul style="list-style-type: none"> ➤ Giving full physical attention. ➤ Being aware of the speaker's non verbal message. <p>Verbal</p> <p>Paying attention to words and feelings that are being expressed.</p> <p>Tips to Promote Listening Capacity</p> <ol style="list-style-type: none"> 1. Look at the speaker. 2. Ask question. 3. Take notes. <p>Hearing is natural. Listening is a skill that we learn. Remember: “we listen more than any other human activity except breathing”!</p> <p>Note- improvement occurs only if you practice these listening skills.</p> <p>Conflict, Criticism, Anger</p> <p>Dealing with Conflict</p> <p>Every human being experiences conflict. It is a factor of human interaction.</p>			
--	--	---	--	--	--




60min	choose right ways to deal with the conflict	<p>Whenever two or more human beings are involved in communication there is potential for misunderstanding, and hence, conflict. How we handle conflict is key to our own well-being and to developing and maintaining good relationships.</p> <p>Ways to deal conflict situation</p> <ol style="list-style-type: none"> 1. Listen carefully to determine the “nature of the conflict” 2. Identify areas of agreement 3. Allow the other person a way out <p>Obstacles to Resolving Conflict</p> <p>Sometimes we can create barriers to resolving conflict effectively. We have confront the problem soon after identifying conflict, If not the issues may become more difficult to resolve.</p> <p>Other obstacles</p> <ol style="list-style-type: none"> 1. Judging a problem too quickly 2. Searching for a single answer, and believing ours is the best 3. Assumption of either/or (either it’s my way or not at all) 4. Deciding that “the problem is theirs, not mine” 	Listening, Lecture cum participating in discussion	Video show, black board and group discussion.	List the ways to solve the conflict situation?
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		<p>How to Overcome Obstacles?</p> <p>List some options toward resolution.</p> <p>List them all (even the ones you really do not want).</p> <p>Find out what the other person can concede.</p> <p>Note- Negotiating a resolution to conflict need not be an “either/or” situation. Both parties in the conflict can win something if there is real effort to resolve the problem. Avoiding resolution will only escalate misunderstanding and may promote anger.</p> <p>Three Tools to effect behavior change</p> <p>Negotiation- Arranging or managing through discussion or compromise</p> <p>Persuasion- To move by argument to a new position or belief</p> <p>Mediation- Intervening in conflict with intent to resolve through discussion.</p> <ul style="list-style-type: none"> ➤ Persuasion involves using information to convince others that there is more than one way to look at an issue. ➤ Mediation usually introduces a third party to the conflict in an effort to resolve problems. <p>Negotiation solutions to conflict</p> <p>“one-point” solution: This technique involves getting feedback in the</p>			
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		<p>communication process, and involves open-ended questions.</p> <p>general feedback question:</p> <p style="padding-left: 40px;">“What is it you really want?”</p> <p>One point solution feedback question:</p> <p style="padding-left: 40px;">“What is the one thing that will make</p> <p style="padding-left: 80px;">You change your mind?”</p> <p>If you only get one response it is usually something</p> <p>Specific to use as the basis for negotiating a solution.</p> <p>Note: To use the one-point solution just keep the number “one” in mind when asking questions.</p> <p>Tips for Resolving Conflict</p> <ul style="list-style-type: none"> ➤ Seek agreement or common ground ➤ Refuse to argue ➤ Seek commitment and action to change ➤ Plot the follow up ➤ Deliver on promises 			
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		<p>Criticism</p> <p>“The act of making judgments and the analysis of qualities and evaluation of comparative worth.”</p> <div data-bbox="499 381 728 574">  </div> <p>Tips for effective criticism</p> <ul style="list-style-type: none"> ➤ Direct your criticism at behavior, not the person ➤ Say something positive ➤ Identify behavior that can be fixed or changed ➤ Avoid use of the word “you” ➤ Avoid negative words like “no, not, never, shouldn’t” ➤ Offer specific ways to make changes in behavior (doable action). <p>Anger</p> <p>From time to time we all become angry. It is a human characteristic. But, we are not born angry, we learn anger.</p> <div data-bbox="1137 1018 1388 1257">  </div> <p>Therefore, it should come as no surprise that we can learn to control it. Although we may not always</p>			
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		<p>successfully control our anger, the more we practice ways to control it, the more we will succeed.</p> <p>Anger can be healthy if we use it to help us understand our reactions to situations. Once we understand how to deal with our own anger.</p> <p> Tips to deal with angry people</p> <ol style="list-style-type: none"> 1. Practice good listening skills (remain silent if necessary) 2. Avoid interruption 3. Acknowledge anger (do not tell an angry person, "Now, don't be angry") 4. Do not yell or lecture angry people (it disrespects their points of view) 5. Be responsive by verifying the person's message 6. Be specific about what you are going to do to help 7. Allow angry people a way out regardless of what they say <p>Practice session</p> <p>Role play(by participants)</p>		Role play	
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90 mins	utilize the art of assertiveness	<p style="text-align: center;">ASSERTIVENESS</p> <div data-bbox="510 252 734 480" data-label="Image"> </div> <p>Assertive communication can strengthen your relationships, reducing stress from conflict and providing you with social support when facing difficult times. Assertive communication can also help you handle difficult family, friends and co-workers more easily, reducing trauma and stress.</p> <p style="text-align: center;">“Assertiveness Training - The Art of Saying No”</p> <p>Assertiveness training-5 methods</p> <p>1. The deal Method for Improving Assertiveness - a step by step process for approaching situations where you want to express yourself better.</p> <p>2. Coping with Anxious Thoughts – The STAR Model - A cognitive behavioral training method for working through anxious thoughts which might be holding you back from being Assertive</p> <p>3. Owning Your Fears - A simple process for confronting and taking control of your fears that the worst may happen (sometimes known as 'fortune telling')</p>	Role play, listening, and participating in role play	Role play and quiz	Why you want to be assertive?
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		<p>4. Rights and Responsibility (R & R) Principles - How to understand and use your rights and responsibilities as a benchmark to help you stand up for yourself whilst respecting others.</p> <p>5. Try it and See (It's Not as Crazy as it sounds) - a practical approach to making changes, maintaining motivation and working through the different stages in becoming assertive based on a model of change.</p> <p>Assertiveness practice in five steps</p> <ol style="list-style-type: none"> 1. When approaching someone about behavior you'd like to see changed, stick to factual descriptions of what they've done that's upset you, rather than labels or judgments. Here's an example <p>Situation</p> <p>Your friend, who habitually arrives late for your plans, has shown up twenty minutes late for a lunch date.</p> <p>Inappropriate- "You're so rude! You're always late."</p> <p>Assertive Communication- "We were supposed to meet at 11:30, but now its 11:50."</p> <ol style="list-style-type: none"> 2. The same should be done if describing the effects of their behavior. Don't exaggerate, label or judge; just describe: 			
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		<p>Inappropriate- “Now lunch is ruined.”</p> <p>Assertive Communication- “Now I have less time to spend lunching because I still need to be back to work by 1pm.”</p> <p>3. Use “I Messages”. Simply put, if you start a sentence off with “You”, it comes off as more of a judgment or attack, and puts people on the defensive. If you start with “I”, the focus is more on how you are feeling and how you are affected by their behavior. Also, it shows more ownership of your reactions, and less blame.</p> <p>For example</p> <p>‘You Message’: “You need to stop that!”</p> <p>‘I Message’: “I’d like it if you’d stop that.”</p> <p>4. Here’s a great formula that puts it all together:</p> <p>“When you [their behavior], I feel [your feelings].”</p> <p>When used with factual statements, rather than judgments or labels, this formula provides a direct, non-attacking, more responsible way of letting people know how their behavior affects you. For example:</p> <p>“When you yell, I feel attacked.”</p>			
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		<p>5. A more advanced variation of this formula includes the results of their behavior (again, put into factual terms), and looks like this:</p> <p>“When you [their behavior], then [results of their behavior], and I feel [how you feel].”</p> <p>Here are some examples:</p> <p>“When you arrive late, I have to wait, and I feel frustrated.”</p> <p>“When you tell the kids they can do something that I’ve already forbidden, some of my authority as a parent is taken away, and I feel undermined.”</p> <p>Practice session</p> <ul style="list-style-type: none"> ➤ Role play. ➤ Assertiveness quiz. <p>Assertiveness quiz</p> <div style="display: flex; align-items: flex-start;">  <div style="margin-left: 20px;"> <p>1. Your mother has just gone an emotional break up and needs some emotional support .your are exhausted after a days’ work and if there is a call from her?</p> </div> </div>			
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		<ul style="list-style-type: none"> a. Not picking but planned to call when you are boosted. b. Pick up the call and say you are exhausted or advice her to overcome. c. Pick up the call and talk to her until she feels better. d. Pick up the call but inform her can talk is time limited. <p>2. You planned to go for your cousin house but you got a work at institution during your visiting day?</p> <ul style="list-style-type: none"> a. Postpone your plan b. Stay at institution. c. Explain them about your wish. <p>3. If you are arguing?</p> <ul style="list-style-type: none"> a. Understand the other people's point Of view. b. Standing on your point of suggestion. c. Just want to finish the argument. <p>4. Someone passing commands about you in this institution?</p> <ul style="list-style-type: none"> a. Reporting to the staff. b. Say nothing. 			
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		<p>c. You pass commands towards them.</p> <p>d. Tell them you don't like passing commands about you.</p> <p>5. If your visitor was late to bring food on the visitors day?</p> <p>a. Waiting for them.</p> <p>b. Say nothing once they reach you.</p> <p>c. Ask them what for they are late.</p> <p>d. Express angry towards them.</p> <p>6. If some blames you for other problem?</p> <p>a. Try to explain the fact.</p> <p>b. Get irritation.</p> <p>c. Avoiding the person who blames you.</p> <p>d. Try to find the solution for the problem.</p> <p style="text-align: center;">PROBLEM SOLVING</p> <p>Einstein is quoted that if he had one hour to save the world he would spend fifty-five minutes defining the problem and only five minutes finding the solution.</p>			
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10 mins	Practice problem identification and problem solving	<p>This quote does illustrate an important point: before jumping right into solving a problem, we should step back and invest time and effort to improve our understanding of it.</p>  <p>Problem</p> <p>Problem is decided by the purpose .If someone wants money and when they have little money, then they have the problem. But someone does not want money; little money is not a problem.</p> <p>Problem Solving</p> <p>Problem solving is a mental process that includes problem finding and problem shaping.</p> <p>Strategies to See the Problem</p> <p>The quality of the solutions we come up with will be in direct proportion to the quality of the description of the problem we're trying to solve.</p>  <p>There are 10 strategies to see the problems from different perspectives.</p> <p>Try to know what is the problem is –</p> 			
80 mins	strategies are taught to solve problem				

		<p>The definition of the problem will be the focal point of all your problem-solving efforts. As such, it makes sense to devote as much attention and dedication to problem definition as possible.</p> <p>Once you identified the problem you will have more abundant and of higher quality of solutions.</p>  <p>Problem Definition Tools and Strategies</p> <p>1. Rephrase the Problem:</p> <p>Rephrase the problem is saying the problems in using different vocabularies but says the same meaning. This phase extends till the clear understanding takes place.</p> <p>2. Expose and Challenge Assumptions</p> <p>Every problem has list of assumptions so no matter how simple the problem is you make a list of assumptions attached with the problem. Many of these assumptions may be inaccurate and could make your problem statement inadequate or even misguided. From the list you explicit the bad assumptions.</p> <p>That, in itself, brings more clarity to the problem at hand. But go further and test each assumption for validity: think in ways that they</p>	Lecture cum discussion	PPT and work sheet.	Specify the problem defining tools?
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		<p>might not be valid and their consequences. What you will find may surprise you: that many of those bad assumptions are self-imposed — with</p> <p>Just a bit of scrutiny you are able to safely drop them.</p> <p>3. Chunk Up</p> <p>Each problem is a small piece of a greater problem. In the same way that you can explore a problem laterally hence break the whole problem in to bits for clear understanding of the problem.</p> <p>4. Chunk Down</p> <p>‘Chunking the problem down’ (making it more specific) is especially useful if you find the problem overwhelming or daunting.</p> <p>5. Find Multiple Perspectives</p> <p>Before rushing to solve a problem, always make sure you look at it from different perspectives. Looking at it with different eyes is a great way to have instant insight on new, overlooked directions.</p> <p>Rewrite your problem statement many times, each time using one of these different perspectives.</p>			
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		<p>6. Use Effective Language Constructs</p> <p>There isn't a one-size-fits-all formula for properly crafting the perfect problem statement, but there are some language constructs that always help making it more effective</p> <p>Assume a myriad of solutions</p> <p>An excellent way to start a problem statement is in what way you can solve the stated problem.</p> <p>Make it positive</p> <p>Negative sentences require a lot more cognitive power to process and may slow you down — or even derail your train of think.</p> <p>Positive statements also help you find the real goal behind the problem and, as such, are much more motivating.</p> <p>For example: instead of finding ways to 'quit smoking', you may find that 'increase your energy', 'live longer' and others are much more worthwhile goals.</p> <p>7. Reverse the Problem</p> <p>One trick that usually helps when you're stuck with a problem is turning it on its head.</p> <p>If you want to win, find out what would make you lose. If you are</p>			
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90 mins	explained about the side effects and other	<p>struggling finding ways to ‘increase sales’, find ways to decrease them instead. Then, all you need to do is reverse your answers.</p> <p>8. Gather Facts</p> <p>Investigate causes and circumstances of the problem. Probe details about it — such as its origins and causes. Especially if you have a problem that’s too vague, investigating facts is usually more productive than trying to solve it right away.</p> <p>If, for example, the problem stated by your spouse is “You never listen to me”, the solution is not obvious. However, if the statement is “You don’t make enough eye contact when I’m talking to you,” then the solution is obvious.</p> <p>8. Problem-Solve Your Problem Statement</p> <p>I know I risk getting into an infinite loop here, but as you may have noticed, getting the right perspective of a problem is, well, a problem in itself. As such, feel free to use any creative thinking technique you know to help to solve your problem.</p> <p>MEDICATION MANAGEMENT</p> <p>AND RELAPSE</p> <p>Antipsychotic are the medications have</p> 			
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	important measures of medication	<p>been given for the treatment of schizophrenia. They effectively alleviate the positive symptoms of schizophrenia. While these drugs have greatly improved their lives but they do not cure schizophrenia. Everyone responds differently to antipsychotic medication. Sometimes several different drugs must be tried before the right one is found. People with schizophrenia should work in partnership with their doctors to find the medications that control their symptoms best with the fewest side effects.</p> <p>Benefits of antipsychotics</p> <p>Relieves symptoms.</p> <p>Keeps the condition from getting worse.</p> <p>Side Effects of Antipsychotics</p> <p>Common side effects of typical anti Psychotic</p> <ul style="list-style-type: none"> ➤ Drowsiness. ➤ Physical restlessness. ➤ Insomnia. ➤ Gastrointestinal issues. ➤ Rapid heart rate. ➤ Dry mouth. 	Listening lecture and group discussion.	Group discussion	List the measures to manage the side effects?
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		<ul style="list-style-type: none"> ➤ Headache. ➤ Blurred vision. ➤ Depression. <p>Extra Pyramidal Side Effects</p> <p>Autonomic side effects</p> <ul style="list-style-type: none"> ➤ Dry mouth. ➤ Constipation. ➤ Cycloplegia. ➤ Mydriasis. ➤ Delirium. ➤ Orthostatic hypotension. <p>Extra Pyramidal Side Effects</p> <ul style="list-style-type: none"> ➤ Parkinsonian syndrome (tremors) <p>Features of Parkinsonian syndrome are</p> <ul style="list-style-type: none"> ○ Expressionless face. ○ Lack of associated(walking, together with rigidity, coarse treatment , stooped postures,) 			
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		<p>➤ Akathisia (motor restlessness).</p> <p>Features of Akathisia are</p> <ul style="list-style-type: none"> ○ Physical restlessness. ○ Inability to keep still. ○ Agitation with suicidal ideation. <p>➤ Acute dystonia (it occurs soon after treatment begins).</p> <p>Features of acute dystonia are</p> <ul style="list-style-type: none"> ○ Torticollis. ○ Tongue protrusion. ○ Grimacing. ○ Opisthotonos. <p>➤ Rabbit syndrome (Peri tremor).</p> <p>➤ Neuroleptic malignant syndrome</p> <p>Features of Neuroleptic malignant syndrome are</p> <ul style="list-style-type: none"> ○ Fever. <p>➤ Metabolic and endocrine side effects</p> <ul style="list-style-type: none"> ○ Weight gain. 			
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		<ul style="list-style-type: none"> ○ Diabetes. ○ Amenorrhea. ➤ Allergic side effects ○ Cholestatic jaundice. ➤ Dermatological side effects ○ Contact dermatitis. ○ Photosensitive reaction. ➤ Other central nervous system effects ○ Seizures. ○ Sedation. <p>Management</p> <ul style="list-style-type: none"> ➤ Doctor's consultation. ➤ Water intake. ➤ Physical exercises. ➤ Sun protection glass. ➤ Skin moisturizer. <p>Drug Compliance</p> <p>Adherence of the clients in using a prescribed medication exactly as ordered by the physician. Noncompliance occurs when a patient</p>			
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		<p>forgets or neglects to take the prescribed dosages at the recommended times or decides to discontinue the drug without consulting the physician.</p> <p>Problems with compliance</p> <p>In mental health compliance is a challenging source because discontinuation of the medication / partial compliance represents. Difficulty of maintaining successful treatment.</p> <p>Strategies to Reduce Drug Compliance</p> <p>Right drug ~ Always carefully see the tablets to check the right drug for time like which has to be taken in the morning, afternoon and night.</p> <p>Right person ~ do not take the medication prescribed for other person e.g.: the drugs may be in the same color for you and other persons of the same disorder but the dosage and action may vary.</p> <p>Right dose ~ Don't take medications more / less than the prescribed dose by the doctor. As this may worsen the condition.</p> <p>Right time ~ Try to stay as close as possible to the scheduled dosage times. (This means that if a medication is scheduled to be given at 1:00 pm, it may be given at any time from 12:00 PM (noon) to 2:00 PM or an</p>			
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		<p>hour before to an hour after the scheduled time. Thus, some medications may be "grouped," and given at the same time. However care must be taken to avoid giving drugs together which are incompatible, would cause adverse side effects, or decrease their effects, if given at the same time or too close together.)</p> <p>No combinations of drugs- Many people have more than one doctor and may take medications that could possibly interact with each other and create a serious health risk (this is known as polypharmacy). Siddha medications, homeopathy, herbal preparation.</p> <p>Tips for Taking Self Medications</p> <ul style="list-style-type: none"> ○ Keep medications visible. ○ Make sure a readable clock is visible. ○ Post reminders, if necessary. ○ Draw a large clock and put color codes on it, if necessary. <p>Diet Management During the Intake of Anti Psychotics</p> <p>Many people have the mistaken notion that, being natural, all herbs and foods are safe. This is not so. Very often, herbs and foods may interact with medications you normally take that result in serious side reactions. It is always a good practice to tell your doctor or health practitioners what you are taking so that they can advise you of possible</p>			
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		<p>complications, if there is any. You should also keep an eye for unusual symptoms. Very often, this may foretell the symptoms of a drug interaction.</p> <p>Experts suggest that natural does not mean it is completely safe. Everything you put in your mouth has the potential to interact with something else. The medication that is taken by mouth travels through the digestive system in much the same way as food and herbs taken orally do. So, when a drug is mixed with food or another herb, each can alter the way the body metabolizes the other. Some drugs interfere with the body's ability to absorb nutrients. Similarly, some herbs and foods can lessen or increase the impact of a drug.</p> <p>Alcoholic beverages- It tends to increase the depressive effects of anti psychotics.</p> <p>Caffeine-when taken with anti psychotics it increases anxiety and reduces the drug's effectiveness</p> <p>Others foods to be avoided as follows</p> <ul style="list-style-type: none"> ➤ Sugar. ➤ Refined carbohydrates. ➤ Cigarettes. ➤ Stimulant drugs.(cocaine) 			
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		<p>All affect the ability to keep one's blood sugar level balanced. On top of this common antipsychotic medication may also further disturb blood sugar control. Stimulant drugs, from amphetamines to cocaine, can induce schizophrenia. The incidence of blood sugar problems and diabetes is also much higher in those with schizophrenia. Therefore it is strongly advisable to eat a low glycemic load diet.</p> <p>Foods to be taken</p> <ul style="list-style-type: none"> ➤ Fiber rich diet. ➤ Fruits. ➤ Vegetables. ➤ Juices. 			
90 mins	prepare the clients to relax by explaining the different simple relaxation techniques	<p style="text-align: center;">RELAXATION TECHNIQUES</p> <p>Relaxation technique helps us find our own way to relax. It helps us to relax both the mind and body.</p> <p>Common methods for relaxation:</p> <p>These will not require special practice / training</p> <p>Sleeping – Simplest and natural way of relaxing.</p> <p>Listening to music – Songs etc.,(based on self interest the songs can be chosen).</p>	Lecture cum discussion.	PPT and video shows.	What are the relaxation techniques suits you for practice?

		<p>Reading - Books, news papers/ any think based on interest which helps to divert the concentration.</p> <p>Talking to someone – Socialization.</p> <p>Talking a long walk/ any form of mild physical exercises.</p> <p>Talking a warm bath / shower.</p> <p>Breathing exercises.</p> <p>Ways to enhance relaxation technique</p> <ul style="list-style-type: none"> ➤ When it becomes every day routine. ➤ Selecting the suitable one based on the need. ➤ Set time. ➤ Select distraction free environment. ➤ Wear loose clothes. ➤ Not after a meal. ➤ Do it in the morning /in the evening. ➤ Lie down or sit in a comfortable table chair (for some relaxation techniques). 			
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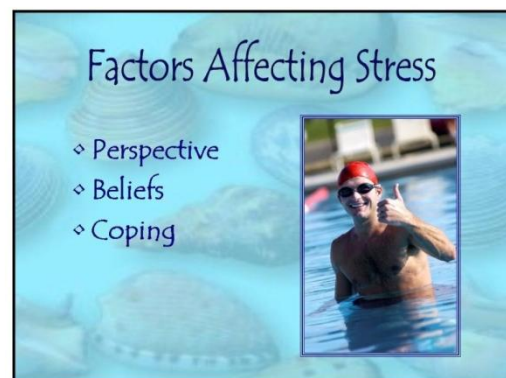
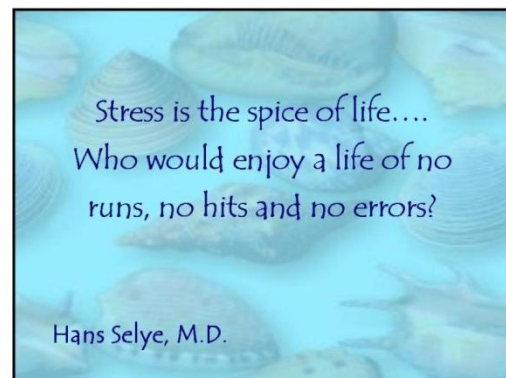
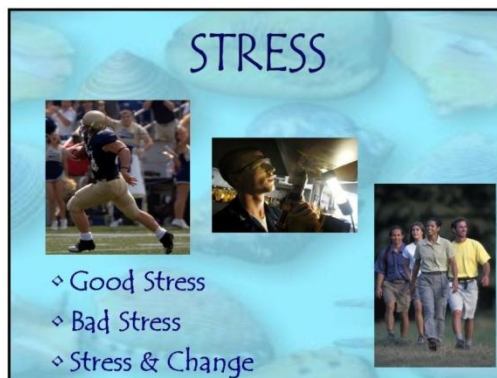
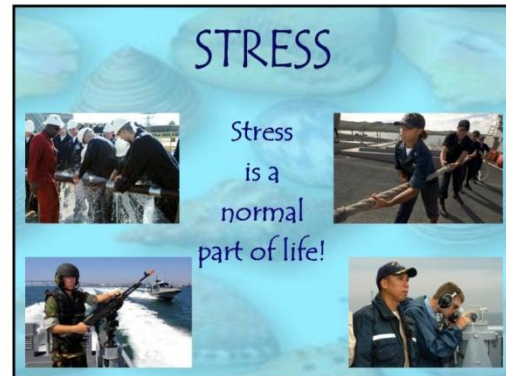
90 mins	truth about stress and their management	<p style="text-align: center;">STRESS MANAGEMENT</p> <p>Introduction</p> <p>Stress is the component which will never leave the individual who lives in this world and this is quiet common in this mechanic world which makes the individual hectic to compete this world. So it's quiet important how the individual perceive tom take measures to solve the problem which produces stress.</p> <p>Definition of stress</p> <p>Stress is the spice of Life. Who would enjoy the life of no runs, no hits and no errors?</p> <p style="text-align: right;">HANS SELYE M.D</p> <p>Types of stress</p> <ul style="list-style-type: none"> <input type="checkbox"/> Good stress <input type="checkbox"/> Bad stress <input type="checkbox"/> Stress of change <p>Stressors</p> <ul style="list-style-type: none"> <input type="checkbox"/> Daily hassles. <input type="checkbox"/> Life events <input type="checkbox"/> time 	Lecture cum discussion.	PPT	Differentiate the stress and coping styles?
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		<p>Factors affecting stress</p> <ul style="list-style-type: none"> <input type="checkbox"/> perspective <input type="checkbox"/> coping <input type="checkbox"/> beliefs <p>Coping with stress</p> <ul style="list-style-type: none"> <input type="checkbox"/> old coping skills <input type="checkbox"/> assess your attitude <input type="checkbox"/> worrying <p>Coping skills:</p> <p>Fly away.</p> <ul style="list-style-type: none"> ➤ Reinterpret. ➤ Positive self talk. ➤ Took your battle. ➤ Relaxation. ➤ Exercise. ➤ Humor. ➤ Rebounding. <p>Coping choices:</p> <ul style="list-style-type: none"> I. Endless options. II. Try different measures. 			
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		<p>III. Revise the strategy.</p> <p>How we can manage stress:</p> <p><input type="checkbox"/> Practice.</p> <p>Stress buster (practice session)</p> <ul style="list-style-type: none"> ➤ Shape matching. ➤ Letter game. ➤ Video show. ➤ Flower arranging. 			
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APPENDIX – XIX



POWER POINT PRESENTATIONS



Coping with Stress



- ◊ Old coping skills
- ◊ Assess your attitude
- ◊ Worrying





"I have known a great many troubles... but most of them never happened."

Mark Twain

Coping Skills

- ◊ Fly Away!
- ◊ Reinterpret





Coping Skills

- ◊ Positive Self Talk
- ◊ Pick your battles

Coping Skills

◊ Relaxation




- ◊ Exercise
- ◊ Humor

Rebounding

- ◊ Avoid seeing a crisis as Impossible or Insurmountable!
–All kinds of things occur, so move on and step over it!
- ◊ Keep things in perspective – may not be as bad or big a deal as you think!
- ◊ Find someone to talk with and hang out!
- ◊ Do something positive!

"The difference between a really good day and a really awful day is not found in what happened but in what you tell yourself about that day"

Thomas Whiteman, Sam Verghese & Randy Peterson

Coping Choices

- ◊ Options are endless!
- ◊ One size doesn't always fit!
- ◊ Strategies need to be revised!

"We can control our reactions and responses to stress. How we cope with stress is up to us"

Jeff Davidson

Stress Continuum

↑ In the zone
Optimistic perspective
Effortless
Positive attitude
Okay with stress
Unhappy
Negative attitude
↓ Troubled


Coping with Stress

- ◊ Takes practice!
- ◊ Learn new skills!
- ◊ Plan
- ◊ Prevention is more effective than reaction!



PROBLEM SOLVING


PROBLEM SOLVING



Einstein quoted that if he had one hour to save the world he would spend fifty-five minutes defining the problem and only five minutes finding the solution.

PROBLEM

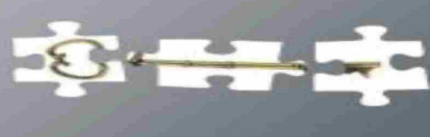
Problem is decided by the purpose .



If someone wants money and when they have little money, then they have the problem. But someone does not want money; little money is not a problem.

Problem Solving

Problem solving is a mental process that includes problem finding and problem shaping.

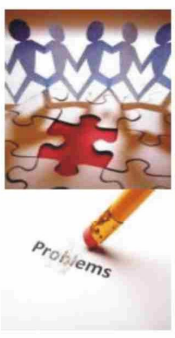



Strategies to See the Problem

10 Strategies

Try to know what is the problem is?

- ① Rephrase the Problem
- ② Expose and Challenge Assumptions
- ③ Chunk Up
- ④ Chunk Down
- ⑤ Find Multiple Perspectives




Rephrase the Problem

Rephrase the problem is saying the problems in using different vocabularies but says the same meaning.

Expose and Challenge Assumptions

Every problem has list of assumptions so no matter how simple the problem is you make a list of assumptions attached with the problem.




Chunk Up

Break the problem in to break pieces.

Chunk Down

Making problem more specific.





Find Multiple perspectives

Before rushing to solve a problem, always make sure you look at it from different perspectives.

Use Effective Language Constructs

There isn't a one-size-fits-all formula for properly crafting the perfect problem statement, but there are some language constructs that always help making it more effective

② Use Effective Language Constructs.

PROBLEM SOLUTION :

② Assume a myriad of solutions.

② Make it positive.

② Reverse the Problem.

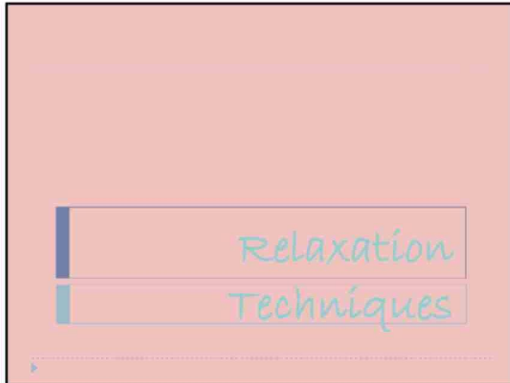
② Gather Facts.

PROBLEM SOLUTION :



Thank you

RELAXATION TECHNICS



Relaxation technique

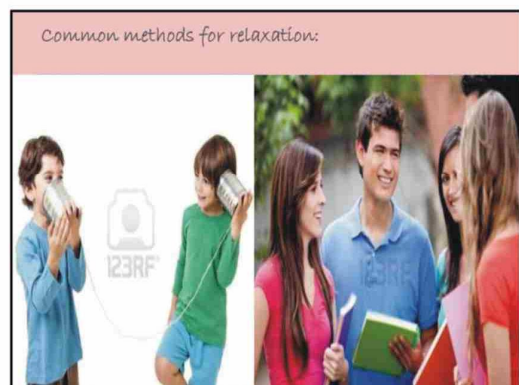
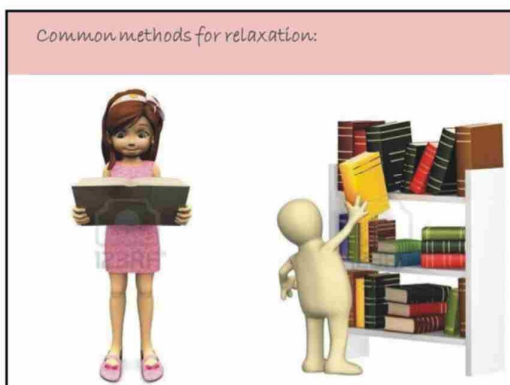
Relaxation technique helps us find our own way to relax. It helps us to relax both the mind and body.

Common methods for relaxation:

These will not require special practice / training



Listening to music



Common methods for relaxation:



Common methods for relaxation:



Common methods for relaxation:



Common methods for relaxation:



Common methods for relaxation:



Common methods for relaxation:



Common methods for relaxation:



Common methods for relaxation:



APPENDIX –XX

WORKSHEET I

Problem Solving

1. Identify and Define Problem Area/Issue

- ✍ try to state the problem as clearly as possible; be objective and specific; describe the problem in terms of what you can observe rather than subjective feelings
- ✍ try to identify what is maintaining the problem rather than just what caused it
- ✍ set realistic and achievable goals for resolving the problem

Problem Definition	Maintaining Factors	Goals for Problem Resolution

2. Generate Potential Solutions

- ✍ list all possible solutions without evaluating their quality or feasibility
- ✍ eliminate less desirable or unreasonable solutions only after as many possible solutions have been listed
- ✍ bearing in mind your goals for problem resolution, list the remaining solutions in order of preference

List of Possible Solutions	Preferred Solutions
	1. _____
	2. _____
	3. _____
	4. _____
	5. _____

3. Evaluate Alternatives

- ✍ evaluate top 3 or 4 solutions in terms of their pros and cons

	Advantages	Disadvantages
Potential Solution #1		
Potential Solution #2		
Potential Solution #3		
Potential Solution #4		

4. Decide on a Solution

- ✍ decide on one or two solutions
- ✍ specify actions and who will take action
- ✍ specify how and when the solution will be implemented



ACTION STEPS	WHO	WHEN

5. Implement Solution

- ✍ implement the solution as planned

6. Evaluate the Outcome

- ✍ evaluate the effectiveness of the solution
- ✍ decide whether a revision of the existing plan or a new plan is needed to address the problem better

APPENDIX - XXI

DATA CODING SHEET

Demographic Variables of Schizophrenic Clients

AGE-Age in Years

1.1 30-40

1.2 41-50

1.3 51-60

GEN - Gender

2.1 Male

2.2 Female

EDU-Educational Status

3.1 Non literate

3.2 primary school

3.3 Secondary

3.4 Higher secondary

3.5 Graduate and above

Occ -Occupation

4.1 Unemployed

4.2 Former

4.3 Laborer

4.4 Technical

4.5 Business

4.6 Professional

4.7 House wife

4.8 Any other

MFI - Monthly Family Income

5.1 5,000-10,000

5.2 10,001-20,000

5.3 20,001-30,000

MS-Marital Status

6.1 Married

6.2 Unmarried

6.3 Separated

6.4 Widow / Widower

REL-Religion

7.1 Hindu

7.2 Muslim

7.3 Christian

7.4 Any other

TOF-Type of Family

8.1 Nuclear

8.2 Joint

AOR-Area of Residence

9.1 Urban

9.2 Rural

DATA CODING SHEET

Clinical Variables of Schizophrenic Clients		Social Skills Questionnaire - NIMHANS
HPH-history of hospitalization	PRC-If present relationship to the client	PSF-patient self report
1.1 Yes	4.1 First degree	COI-clinician observation during interview
1.2 No	4.2 Second degree	OI-others information
SHC-source of help sought by the clients	4.3 Third degree	LOS-level of satisfaction
2.1 Traditional healing	HVB-history of violent behavior	76-100% highly satisfied
2.2 Traditional priest	5.1 present in the past	51-75% satisfied
2.3 Churches	5.2 present at present	25-50% Dissatisfied
2.4 Mosques	5.3 Never	>25% Highly dissatisfied
2.5 Black magic	ILT- interval between illness and treatment	
2.6 Exorcist	6.1 Immediately	
2.7 Any other specify	6.2 Upto 1 year	
2.8 Medical facility	6.3 >1 year	
FHM-family history of mental illness	6.4 not sure	
3.1 Present		
3.2 Absent		

APPENDIX - XXII															
MASTER CODE SHEET															
CONTROL GROUP															
	Demographic Variables of Schizophrenic Clients									Clinical variables of Schizophrenic Clients					
S.no	GEN	AGE	EDU	OCC	MFI	MS	REL	TOF	AOR	HPH	SHC	FHM	PRC	HVB	ILT
1	1.2	2.3	3.1	4.1	5.1	6.1	7.1	8.1	9.2	1.1	2.2	3.1	4.1	5.1	6.1
2	1.2	2.3	3.3	4.1	5.1	6.1	7.1	8.1	9.2	1.1	2.6	3.1	4.1	5.1	6.1
3	1.1	2.2	3.5	4.4	5.2	6.2	7.1	8.2	9.1	1.1	2.7	3.1	4.2	5.1	6.1
4	1.1	2.1	3.2	4.1	5.1	6.2	7.3	8.1	9.1	1.1	2.7	3.2		5.2	6.3
5	1.1	2.2	3.2	4.3	5.3	6.1	7.1	8.2	9.2	1.2	2.7	3.2		5.1	6.4
6	1.1	2.1	3.1	4.1	5.1	6.2	7.2	8.1	9.1	1.2	2.7	3.1	4.3	5.3	6.2
7	1.2	2.2	3.4	4.2	5.2	6.3	7.1	8.1	9.1	1.1	2.8	3.1	4.1	5.3	6.3
8	1.2	2.3	3.3	4.6	5.1	6.4	7.1	8.1	9.1	1.1	2.1	3.1	4.2	5.3	6.1
9	1.1	2.2	3.2	4.5	5.3	6.1	7.3	8.2	9.2	1.1	2.3	3.2		5.1	6.1
10	1.1	2.3	3.5	4.2	5.1	6.1	7.2	8.1	9.1	1.2	2.5	3.1	4.1	5.1	6.2
11	1.1	2.2	3.5	4.4	5.2	6.3	7.1	8.1	9.1	1.1	2.7	3.2		5.1	6.1
12	1.1	2.3	3.1	4.1	5.1	6.4	7.1	8.1	9.1	1.2	2.4	3.2		5.2	6.1
13	1.1	2.1	3.5	4.3	5.1	6.1	7.1	8.1	9.1	1.2	2.8	3.2		5.1	6.1
14	1.1	2.2	3.4	4.5	5.3	6.1	7.1	8.1	9.1	1.1	2.1	3.1	4.2	5.3	6.4
15	1.1	2.2	3.4	4.5	5.1	6.1	7.1	8.1	9.2	1.1	2.2	3.1	4.1	5.2	6.3
16	1.1	2.3	3.4	4.5	5.3	6.1	7.3	8.1	9.1	1.1	2.8	3.2		5.3	6.1
17	1.1	2.3	3.3	4.5	5.3	6.1	7.1	8.1	9.1	1.1	2.2	3.1	4.1	5.1	6.4
18	1.2	2.3	3.5	4.1	5.1	6.1	7.1	8.2	9.2	1.1	2.5	3.2		5.1	6.2
19	1.2	2.1	3.4	4.1	5.1	6.1	7.1	8.1	9.1	1.1	2.8	3.2		5.2	6.1
20	1.2	2.1	3.3	4.1	5.1	6.2	7.1	8.1	9.2	1.1	2.3	3.2		5.1	6.1
21	1.1	2.1	3.3	4.1	5.2	6.1	7.1	8.1	9.2	1.2	2.7	3.1	4.1	5.1	6.1
22	1.1	2.2	3.1	4.1	5.1	6.1	7.2	8.1	9.1	1.1	2.7	3.1	4.1	5.3	6.3
23	1.1	2.3	3.1	4.1	5.1	6.1	7.3	8.2	9.1	1.1	2.2	3.1	4.1	5.1	6.2
24	1.1	2.1	3.3	4.3	5.3	6.1	7.3	8.2	9.1	1.1	2.8	3.2		5.2	6.1
25	1.2	2.2	3.5	4.7	5.1	6.4	7.1	8.1	9.2	1.2	2.7	3.1	4.2	5.2	6.1
26	1.2	2.3	3.4	4.4	5.3	6.4	7.1	8.1	9.2	1.1	2.1	3.1	4.2	5.2	6.4
27	1.1	2.2	3.2	4.1	5.1	6.2	7.1	8.1	9.2	1.1	2.7	3.1	4.1	5.2	6.1
28	1.2	2.3	3.2	4.7	5.1	6.2	7.1	8.2	9.1	1.1	2.7	3.1	4.3	5.1	6.4
29	1.1	2.3	3.5	4.1	5.1	6.1	7.1	8.1	9.1	1.2	2.7	3.1	4.1	5.1	6.2
30	1.2	2.3	3.5	4.7	5.1	6.3	7.1	8.2	9.1	1.2	2.8	3.2		5.3	6.1

APPENDIX - XXII															
MASTER CODE SHEET															
Experimental Group															
Demographic Variables of Schizophrenic Clients										Clinical variables of Schizophrenic Clients					
S.no	GEN	AGE	EDU	OCC	MFI	MS	REL	TOF	AOR	HPH	SHC	FHM	PRC	HVB	ILT
1	1.1	2.1	3.4	4.8	5.1	6.2	7.1	8.1	9.1	1.1	2.8	3.1	4.1	5.3	6.1
2	1.1	2.1	3.3	4.1	5.1	6.2	7.1	8.1	9.1	1.1	2.8	3.1	4.1	5.1	6.3
3	1.1	2.2	3.4	4.2	5.1	6.3	7.1	8.2	9.1	1.1	2.7	3.2	-	5.3	6.2
4	1.2	2.3	3.3	4.1	5.1	6.2	7.1	8.1	9.1	1.1	2.2	3.1	4.1	5.3	6.2
5	1.2	2.1	3.5	4.3	5.2	6.1	7.1	8.2	9.2	1.2	2.1	3.1	4.1	5.3	6.1
6	1.1	2.3	3.3	4.5	5.1	6.2	7.1	8.2	9.1	1.1	2.6	3.2	-	5.1	6.4
7	1.1	2.3	3.4	4.8	5.2	6.2	7.1	8.1	9.1	1.1	2.8	3.2	-	5.2	6.1
8	1.1	2.2	3.3	4.4	5.3	6.2	7.1	8.2	9.1	1.1	2.2	3.2	-	5.2	6.1
9	1.1	2.1	3.5	4.4	5.1	6.2	7.1	8.1	9.1	1.1	2.8	3.1	4.1	5.3	6.1
10	1.1	2.2	3.4	4.8	5.1	6.2	7.1	8.1	9.1	1.1	2.7	3.1	4.1	5.2	6.3
11	1.1	2.2	3.5	4.8	5.1	6.2	7.1	8.2	9.1	1.1	2.7	3.2	-	5.3	6.2
12	1.1	2.2	3.4	4.4	5.1	6.2	7.1	8.2	9.1	1.1	2.8	3.2	-	5.1	6.1
13	1.1	2.3	3.5	4.4	5.1	6.2	7.1	8.2	9.1	1.1	2.8	3.1	4.1	5.2	6.1
14	1.1	2.2	3.4	4.1	5.1	6.3	7.2	8.1	9.1	1.1	2.2	3.1	4.2	5.3	6.3
15	1.1	2.3	3.5	4.8	5.1	6.1	7.1	8.2	9.1	1.1	2.7	3.2	-	5.3	6.1
16	1.2	2.1	3.1	4.3	5.1	6.1	7.1	8.2	9.1	1.1	2.7	3.1	4.1	5.1	6.1
17	1.1	2.1	3.5	4.6	5.2	6.2	7.1	8.1	9.1	1.2	2.8	3.2	-	5.2	6.1
18	1.1	2.3	3.4	4.1	5.1	6.2	7.1	8.1	9.1	1.1	2.8	3.1	4.1	5.1	6.3
19	1.1	2.1	3.4	4.1	5.1	6.2	7.1	8.2	9.1	1.1	2.3	3.1	4.1	5.1	6.4
20	1.2	2.2	3.1	4.2	5.1	6.1	7.2	8.1	9.2	1.1	2.7	3.2	-	5.1	6.2
21	1.2	2.3	3.5	4.5	5.3	6.1	7.3	8.2	9.2	1.2	2.4	3.1	4.3	5.1	6.4
22	1.1	2.3	3.3	4.2	5.2	6.1	7.1	8.2	9.2	1.1	2.3	3.1	4.1	5.1	6.1
23	1.2	2.1	3.1	4.1	5.2	6.4	7.3	8.2	9.2	1.1	2.5	3.1	4.1	5.1	6.4
24	1.1	2.1	3.5	4.8	5.1	6.3	7.3	8.1	9.1	1.1	2.2	3.1	4.2	5.2	6.3
25	1.2	2.3	3.5	4.8	5.3	6.2	7.2	8.1	9.2	1.1	2.7	3.2	-	5.3	6.2
26	1.2	2.2	3.2	4.7	5.2	6.1	7.1	8.2	9.2	1.1	2.1	3.1	4.1	5.1	6.1
27	1.2	2.3	3.5	4.1	5.3	6.4	7.3	8.1	9.2	1.1	2.5	3.1	4.3	5.1	6.1
28	1.2	2.1	3.2	4.2	5.2	6.3	7.3	8.2	9.1	1.2	2.6	3.1	4.1	5.3	6.1
29	1.1	2.3	3.1	4.6	5.2	6.3	7.2	8.1	9.1	1.2	2.1	3.1	4.1	5.1	6.3
30	1.2	2.1	3.2	4.7	5.3	6.3	7.2	8.2	9.2	1.1	2.7	3.1	4.1	5.2	6.2

APPENDIX - XXII																								
MASTER CODE SHEET																								
CONTROL GROUP																								
Sample No	PRE TEST / SSTP												POST TEST / SSTP											
	PSR					COI						OI	PSR						COI					OI
	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12
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3	1	1	1	2	2	2	2	3	4	2	3	1	1	2	3	2	3	2	2	3	3	2	2	3
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10	3	2	1	2	3	1	2	2	4	3	3	4	2	2	4	2	1	2	2	3	3	1	2	2
11	1	1	4	1	4	2	1	4	3	1	2	2	4	3	2	1	1	2	2	2	4	1	2	3
12	3	3	2	1	2	4	2	2	4	2	2	4	3	3	1	2	3	1	2	4	2	3	1	3
13	3	2	3	2	3	1	2	3	1	2	1	3	4	1	4	2	2	2	2	3	1	2	1	1
14	1	2	2	3	1	2	1	1	2	3	1	1	2	2	2	2	1	1	1	2	1	2	1	1
15	4	4	3	3	2	2	3	1	2	2	2	4	4	4	3	3	2	2	1	2	2	1	2	4
16	4	2	3	2	3	2	2	4	3	1	2	1	2	3	4	2	1	4	2	2	1	3	1	3
17	1	2	2	4	1	2	2	3	1	1	3	2	2	2	4	2	1	3	2	4	3	2	1	2
18	4	4	2	3	2	2	2	1	4	4	2	4	2	2	3	4	2	4	2	1	3	4	1	4
19	4	3	4	2	1	2	1	1	2	2	2	2	3	2	1	2	3	3	2	1	2	2	1	2
20	2	3	2	4	1	2	2	1	3	3	1	2	4	2	3	2	2	2	2	2	4	1	2	2
21	2	3	4	3	2	4	3	3	2	4	3	3	4	3	4	2	3	4	3	4	2	2	2	4
22	4	2	3	2	1	2	3	3	2	1	1	1	1	2	2	3	1	4	1	3	1	1	2	1
23	4	3	3	4	2	4	3	2	2	1	2	3	3	4	4	1	1	4	3	4	2	1	1	2
24	2	3	3	1	2	2	4	3	2	2	2	2	2	2	3	3	2	2	3	1	2	2	1	2
25	1	2	4	1	1	2	3	4	4	4	3	3	4	4	4	4	3	1	2	2	1	3	1	3
26	3	2	3	2	2	2	2	1	2	2	1	2	2	2	2	2	2	1	2	2	2	1	1	1
27	4	3	4	4	4	4	2	2	1	2	1	1	4	4	3	2	3	3	1	2	3	1	2	2
28	2	2	1	1	2	2	1	2	2	2	1	2	2	3	2	1	2	2	1	1	2	1	2	2
29	4	3	4	2	4	1	2	2	2	2	3	1	3	4	3	2	4	1	2	3	3	1	2	1
30	3	2	3	1	3	1	1	2	1	2	1	1	4	2	3	1	2	2	1	1	2	1	2	2

APPENDIX - XXII																										
MASTER CODE SHEET																										
EXPERIMENTAL GROUP																										
PRE TEST / SSTP													POST TEST / SSTP													
Sample No	PSR					COI						OI	PSR					COI						OI	LOS	
	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12		
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2	2	2	4	3	3	2	3	2	1	1	2	3	3	4	3	4	2	3	3	3	3	3	4	4	95	
3	3	4	2	2	2	2	2	3	3	2	1	3	4	4	2	4	3	3	4	4	3	3	4	4	92.5	
4	1	3	4	4	2	2	3	1	2	1	1	3	3	3	3	4	2	3	3	3	4	3	4	4	97.5	
5	3	3	3	3	4	1	1	1	3	2	2	2	3	4	4	4	4	3	3	2	3	2	4	4	92.5	
6	2	4	1	1	4	4	3	3	3	4	3	3	4	4	4	4	2	4	3	4	4	2	4	4	92.5	
7	1	1	1	1	3	2	2	3	4	2	3	1	3	4	2	2	3	3	4	3	4	3	4	4	92.5	
8	1	2	2	2	3	2	2	3	4	3	4	3	3	4	4	4	1	4	2	3	4	3	4	4	95	
9	2	2	2	3	4	2	1	1	3	3	1	4	4	3	4	4	4	3	2	3	4	4	4	4	95	
10	2	2	2	1	2	1	2	2	3	2	2	1	3	4	3	4	2	4	3	4	4	4	4	4	90	
11	4	4	3	3	3	2	2	1	4	2	2	2	4	4	2	4	4	3	3	4	4	3	4	4	95	
12	4	4	2	3	2	4	3	2	2	1	2	2	4	4	4	3	1	3	3	4	4	2	4	4	95	
13	2	4	3	4	1	4	3	3	4	3	4	4	4	4	3	4	4	4	3	3	4	3	4	4	97.5	
14	3	4	1	3	1	2	2	2	4	3	4	3	4	4	3	3	2	3	4	3	4	4	4	4	90	
15	3	3	2	2	4	1	1	2	2	3	3	3	3	4	3	4	3	3	3	3	4	4	4	4	98	
16	4	4	4	4	3	3	1	1	2	3	3	2	4	4	4	4	4	4	2	3	2	4	4	4	97.5	
17	2	3	1	3	2	4	2	2	4	3	3	1	4	4	2	4	4	4	3	3	4	4	4	3	97.5	
18	2	1	1	2	4	1	2	3	2	2	3	2	4	4	4	4	1	3	2	3	4	4	4	4	97.5	
19	3	3	4	4	3	3	2	2	3	3	3	2	4	4	4	3	2	3	2	3	4	4	4	4	97.5	
20	3	2	3	3	3	1	1	3	1	4	3	4	4	4	4	4	3	4	4	4	3	3	4	4	90	
21	2	2	2	2	4	2	1	2	2	2	2	1	3	4	4	3	2	4	4	3	4	4	4	3	90	
22	1	2	3	2	3	3	1	3	2	2	2	2	4	3	4	2	3	3	3	4	3	3	4	4	85	
23	3	3	3	2	1	2	3	1	4	3	3	4	4	4	4	3	3	4	3	4	2	4	4	4	97.5	
24	1	2	2	1	1	1	1	3	3	3	1	1	2	2	4	4	2	3	1	2	2	1	1	3	90	
25	4	2	1	2	2	1	3	4	3	2	2	4	4	4	4	4	3	3	2	3	3	2	2	4	90	
26	2	2	4	3	2	3	1	1	3	1	1	3	2	4	3	3	3	3	1	1	4	2	1	3	88.5	
27	3	3	2	2	2	3	4	4	2	4	2	4	4	4	4	4	3	3	4	3	4	4	4	4	88.5	
28	1	2	3	3	2	2	3	2	2	2	1	4	4	4	3	4	3	3	4	4	3	2	3	4	97.5	
29	1	2	2	2	3	2	3	3	3	3	4	3	3	4	3	4	2	3	4	2	4	2	4	4	97.5	
30	3	3	2	2	1	1	1	3	4	3	1	1	3	4	4	4	2	2	3	3	2	2	3	4	97.5	